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ABSTRACT

Information on the prevention of child maltreatment is provided, as well as methods and programs to respond to the maltreatment of children with disabilities, ages birth to 5 years. Challenges to providing effective service delivery are addressed, along with the family perspective and total family needs. Risk factors that affect family functioning are addressed, with attention to: the issue of parents who as children were subjected to maltreatment, normal infant development patterns and distorted patterns, responses that may occur when working with adult survivors, and working with new mothers and postpartum depression. In considering alternative family designs and risk factors, attention is directed to single-parent families, step families, foster and adoptive families, teen parents, extended families, and characteristics of strong families. Child neglect, substance abuse, domestic abuse, and community violence are also discussed. The value of assistance from various resources is considered, including parent-to-parent support, training of foster parents to be parent aides, family resource centers, "Friends of the Family" program in Baltimore, Maryland, mothers as mentors, home visitation programs, and parent training and information centers. Appendices provide information on 10 model support programs, regional Parent Training Information (PTI) centers and the states they serve, and the Family Preservation Act. (Each chapter contains references.) (SW)

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RISKY SITUATIONS: VULNERABLE CHILDREN

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Working with families who have children, ages birth to 5, who are at risk of maltreatment with a focus on disabilities

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Risky Situations: Vulnerable Children

Working with families
who have children, ages birth to 5,
who are at risk of maltreatment
with a focus on disabilities

Prepared by PACER Center

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Redeeming Love

Words and music by Marti Erickson

I was just a child,
Wise before my time,
Hurt and confused that the ones I looked up to,
Could crush my spirit, wound my tender heart.

Why'd they hurt me so?
Where was I to go?

So I blocked the pain,
Buried deep inside,
Painted a smile for the world to see,
That would keep my secret, even from me.

Then one day I had a child,
A son to call my own,
Looking to me for all that he needed,
But all I found was emptiness inside.

Afraid I'd hurt him so,
Where was I to go?

I looked into his eyes,
And saw my churning soul,
Rediscovered the pain that was binding my heart,
And then slowly I began to let it go.

Why'd they hurt me so?
I will never know.

But redeeming love is right here, right now,
If I only can reach out and grasp it somehow,
Then releasing the pain that is binding my heart,
I can find the strength to make a brand new start.

Though it hurts me still,
And it always will.

Redeeming love is right here, right now,
And so I reach out and grasp it somehow,
Then releasing the pain that has bound my heart,
I find the strength to make a brand new start.

Available from Album/A Place in My Heart • P.O. Box 19004 • Minneapolis, MN 55419

Introduction

"The scale of the problem of child maltreatment is enormous, its nature is complex, and its significance is profound."

Report from the U.S. Advisory Board on Child Abuse and Neglect [1]

The statistics on child abuse and neglect are staggering.

- In 1992 approximately three million children were victims of childhood maltreatment.[2]
- The incidence of maltreatment among children with disabilities was 1.7 times higher than the incidence among children without disabilities.[3]
- Maltreatment contributed to or was likely to have led to disabilities for 37% of maltreated children with disabilities.[4]

Reasons for the escalating numbers of disabilities include alcohol and other drug abuse by the mother during pregnancy and the maltreatment of young children by their parents and other caregivers. As a result, children with disabilities are a growing population.

Children with disabilities are of particular concern because of their greater vulnerability paired with their special needs.

But now is not the time for despair. As has been demonstrated so often throughout history, negative trends can be reversed by positive leadership, determination and the rigorous efforts of caring people.

We at PACER predict an ongoing crisis for youth in America: both for today's children as well as tomorrow's. What we adhere to is the belief that by sharing information and insights, pooling our resources, engaging in cooperative — not competitive — efforts, we can bring about a solution to problems that may look unsolvable to any one of us viewing them alone.

Parents who have children with disabilities, and advocates and professionals who work with these special children have all witnessed the positive outcomes that can result from sensitive, informed caregiving and unyielding determination.

The increase in the number of children who are born with disabilities or who develop them as a result of maltreatment makes difficult reading. We become empowered with the knowledge that a solution will be there when we are unified in our focus and coordinate our energies.

Who are these children at risk? What are the barriers that prevent families from receiving help? How can professionals encourage participation by the families they serve? What will it take to stop this epidemic?

PACER Center's Let's Prevent Abuse (LPA) Project is a national training model for working with families whose children, from birth to age 5, are at risk for maltreatment. The training focus is on families of children with disabilities.

This resource book is intended to serve as a starting point for professionals and parents. It provides information on the prevention of child maltreatment drawn from research in the area of family support. It describes methods and programs to respond to the maltreatment of children with disabilities. It identifies some of the challenges we must successfully face if more effective service delivery is to occur. Above all, this resource book considers the family perspective and total family needs.

PACER's hope is to create a better understanding of what needs to be done to prevent child maltreatment among children with disabilities and to more appropriately respond to it once it has occurred.

Chapter citations

1. U.S. Advisory Board on Child Abuse and Neglect. 1991 report, cited in *Virginia Child Protection Newsletter*, 38 (Winter 1992).
2. McCurdy, Karen, and Daro, Deborah. Current Trends on Child Abuse Reporting and Fatalities: The Results of the 1992 Annual Fifty State Survey. Chicago: National Committee to Prevent Child Abuse. Working paper 808.
3. "A Report on the Maltreatment of Children with Disabilities." National Center on Child Abuse and Neglect, Administration on Children, Youth and Families, Administration for Children and Families, U.S. Department of Health and Human Services, 1993.
4. Ibid.

Resources

National Committee to Prevent Child Abuse
332 So. Michigan Avenue, Suite 1600
Chicago, IL 60604
Phone: 312-663-3520

Virginia Child Protection Newsletter
James Madison University
Department of Psychology
Harrisonburg, VA 22807

When Survivors Become Parents

Identifying parental backgrounds

To better understand how some parents become trapped in cycles of neglect and abuse, the roots of this behavior must be described.

Most people raise children by imitating the methods their parents used with them. A child whose parents used inappropriate methods of discipline or behavioral control, as a parent may employ those same inappropriate methods with her or his children.

Illustration by Martha Perske

People abused as children do not automatically abuse their children. They are at much greater risk to do so, however, if there is not appropriate intervention. While childhood experience does not excuse abuse, it does establish a powerful and personal reference point — especially on issues of discipline. Parents who were abused as children need to learn which of the punishments they were subjected to were abusive. They may then be empowered to break that chain of abuse in their own child-rearing.

One professional shared:

"When I find myself getting truly stuck in working with a parent, one of the tools I use internally is to ask myself: What experiences did this parent have as a child that could be triggering the issues now being discussed? Which of those experiences still could be unresolved and causing this current difficulty? What are this parent's needs which are not currently being met? Finally, which of this parent's strengths could be enhanced and developed? This strategy doesn't always work; however, it does allow me not to personalize the immediate interaction and to remain an objective, less judgmental participant."

Many professionals believe that a person's internal working model of self and how he or she relates to others becomes defined in the first five years of life. How a child will react to the world around him or her is largely determined by that time. When the primary caregiver responds to the

infant's emotional and physical needs in a healthy and satisfying manner, a secure attachment forms. For most children, this process is completed around the age of 3.

Infants who are maltreated during their first two years of life may suffer more serious consequences than those maltreated from age 5 and older. Dr. Martha Erickson of the Minnesota Mother Child Research Project[1] found that children who were maltreated early in life, regardless of whether the maltreatment still continued, did not function as well cognitively. Children who had been maltreated early in life were less confident, less assertive and less imaginative than children who were maltreated after early childhood development milestones had passed appropriately.

Children resolve many situations through play. If a child's social skills are underdeveloped or characterized by aggressive, inappropriate behavior in interactions with other children, that child will not be accepted. This leads to a tragic cycle: children who are victims of maltreatment by their parents often exhibit aggressive or inappropriate behavior with their peers who then negatively respond. The result is that the child again feels rejection while lacking the coping and problem-solving skills to break the cycle.

Adult survivors of childhood maltreatment — whose needs are not met during those first critical years of life — are forced to adopt behaviors that enable them to survive in

Development of infants

Normal patterns

0 to 12 months	12 to 24 months	24 to 36 months	36 to 60 months
Parent establishes regular eating and sleeping times for the baby. Parent provides the infant with appropriate toys and play so the baby is stimulated but not overwhelmed. Parent is consistent in her/his behavior so the baby feels secure. Parent is loving and warm when holding and talking to the baby.	Parent teaches the baby how to talk and play. Parent teaches the baby how to express a variety of feelings. Parent sets limits for the baby in a calm, consistent fashion. Parent teaches the baby how to accept separations and reunions.	Parent continues teaching the child to play, talk and to label and understand positive emotions, such as love. Parent consistently sets limits and provides structure. Parent shows love and acceptance.	Parent teaches the child how to get along with others and share. Parent sympathizes when the child is hurt or sad. Parent encourages independence and creativity within specific boundaries. Parent helps child control anger and aggressive behavior.

Distorted patterns

0 to 12 months	12 to 24 months	24 to 36 months	36 to 60 months
Infant is extremely irritable. There is no regular pattern in eating and sleeping. The baby is indifferent in behavior towards objects and people and does not appear secure with parents. Infant's emotions are unpredictable and intense in times of stress and frustration.	Baby acts out anger and aggression but does not learn how to verbally express feelings. Baby is slow in learning to talk and play. Baby requires needs to be met immediately. Baby does not accept limits and acts out or feels extreme anxiety when parent leaves.	Child is still unable to control anger and physical aggression towards others. Child has a short attention span and does not play well alone or with other children. Child cannot control impulses, has difficulty caring about and getting along with other children.	Child easily gets angry, acts out and feels rejected. Child cannot cope with stress and frustration. Child is not interested in play that involves language or in learning new activities.

Peters, R.D., McMahon, R.J., & Quinsey, V.L. (1992). Adapted from Disturbed Development Patterns: Aggression and Violence Throughout the Life Span. Sage Publications, Inc., 2455 Teller Road, Newbury Park, CA 91320.

abusive environments. The behaviors, though maladaptive, are actually ingenious survival skills and may include denial, lying, isolation, and aggression. Without intervention or adequate assistance, the survival skills continue in adulthood. They become incorporated into the adult's daily behavior and frequently are labeled "dysfunctional" by professionals.

It can be difficult to facilitate the necessary changes if intervention focuses solely on eliminating the behaviors that negatively impact a parent-child relationship without examining why those behaviors developed in the first place. Professionals and parents may need to work together to examine when the parents' behaviors were formed and why. The next step is to assess how these behaviors may negatively affect them as adults and be counterproductive in their role as parents. Parents can then consider new behaviors that would better serve them. Once the parents are prepared to practice these new behaviors, the professionals must provide adequate feedback and unconditional support.

Responses that may occur when working with adult survivors

When working with adult survivors of abuse, professionals should anticipate that inconsistent or disruptive behaviors may surface and interfere with the process.

It can take a long time for professionals to gain the trust of adult survivors. Some studies show that up to 12 visits may be required before there is sufficient trust for an intervention to begin.[2] Until that trust is established, adult survivors might miss appointments, not complete the assigned work, deny that any difficulties exist and not follow through with the care plan.

Adult survivors sometimes re-experience feelings associated with their victimization. This often occurs at critical times, such as when they leave home for the first time, marry, have their first child, experience the death of a parent (either the offender or the non-offender) or when their children reach the age at which their own victimization began.

These issues can become more complicated when working with parents of children with disabilities because: a) children with disabilities do not follow the same developmental paths as other children, and b) the parents of children with disabilities may not have the time, the energy or the familiarity with resources to seek help for their own issues.

Flashbacks

Flashbacks are common among victims of childhood sexual or physical abuse as well as people diagnosed with post traumatic stress disorder. Flashbacks can be triggered by any of the senses. A survivor may experience flashbacks when subconscious memories of sexual victimization begin to surface. Some survivors say they have "pictures in their heads" of the incidents of actual maltreatment, but since they may have no conscious recollection of those events,

they fear they are "going crazy" when these flashbacks occur.

Many survivors say that when they begin to explore past experiences in therapy, flashbacks increase. They say that these intrusive thoughts can appear at the most inopportune times, such as during a social gathering or while playing with their children, or simply while on a walk.

Understandably, survivors are troubled by the fact that flashbacks seem to have a power all their own. While survivors want control over their own thought processes, first they need to have the vocabulary to understand what is happening to them.

The effects of flashbacks can vary. Survivors may have difficulty concentrating; they may feel overwhelming guilt and shame; they may be aggressive and rageful; they may have recurring nightmares or trouble with their memory; they may avoid a geographic area or a part of their homes. Flashbacks can make survivors severely anxious, produce psychosomatic complaints, make physical and emotional intimacy difficult, and create a sense of numbness that affects the person's overall functioning. Flashbacks can produce fears in survivors that they cannot adequately protect their children, and, as a result, some parents may become overprotective.

Post traumatic stress disorder

PTSD is a response to situations with extreme stress. Symptoms include intense fear, helplessness or horror, persistent re-experiencing the traumatic event, or persistent avoidance of stimuli.

In the past decade, the definition has been expanded to include symptoms manifested in individuals who have experienced abuse or live in environments plagued with violence.

Those experiencing flashbacks often face a variety of obstacles, such as:

► Denial

Because they are frightened by the experience and do not understand it, some survivors try to deny that it happened, which leaves them with feelings of great uncertainty.

► Finding a competent therapist

Survivors typically want a therapist skilled in treating flashbacks. They also may want a therapist who is culturally competent and who understands the dynamics in families who have children with disabilities. Unfortunately, there are not always therapists available who have such a mix of skills.

► Health insurance restrictions

Many health maintenance organizations (HMOs) and other health insurance providers will cover a fixed number of treatment sessions whether or not that number is sufficient for addressing the problem. Survivors also may be restricted in their choice of therapists to those on a specified list.

With appropriate treatment, flashbacks usually will subside. Many survivors say that as they faced their fears with a counselor, they were able to gain control over invasive thoughts and responses. Once they have worked through the victimization, many survivors either cease to experience flashbacks or will have them less frequently.

Dissociation

Dissociation is a psychological mechanism used to cope with traumatic events. It alters a person's memory or identity feelings, and this change may be sudden or gradual. Dissociation can replace a survivor's customary identity with a new one; or the customary identity may be replaced with a feeling of unreality. A person experiencing a dissociative episode may, for example, appear to be daydreaming or "spacing out."

The following examples illustrate two of the many forms dissociation can take:

► Identity replacement

A child talks about abuse as if she were an observer instead of the victim. She talks about being in a corner of a room and watching the abuse take place.

Many children who have been abused describe their experiences in that "third party observer" fashion. While they personally endure the abuse, dissociation serves

A look at Dissociative Disorders

The Diagnostic and Statistical Manual of Mental Disorders defines Dissociative Disorders as "a disruption in the usually integrated functions of consciousness, memory, identity, or perception of the environment. The disturbance may be sudden or gradual, transient or chronic."

Four types of dissociative episodes are identified. The first "is characterized by an inability to recall important personal information, usually of a traumatic or stressful nature, that is too extensive to be explained by ordinary forgetfulness."

The second "is characterized by sudden, unexpected travel away from home or one's customary place of work, accompanied by an inability to recall one's past and confusion about personal identity or the assumption of a new identity."

The third "is characterized by the presence of two or more distinct identities or personality states that recurrently take control of the individual's behavior accompanied by an inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness."

The fourth "is characterized by a persistent or recurrent feeling of being detached from one's mental processes or body that is accompanied by intact reality testing."

Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, 1994, p. 477. American Psychology Association, 720 First St. NE, Washington, DC 20002-4242.

as a mechanism to remove their minds from an experience they simply cannot tolerate.

► Feeling of unreality

A young woman awakens from a nap and describes the feeling of floating above herself as an observer. Her psychologist later explained this as a dissociative episode. A person's body and mind can take only so much trauma before something has to give.

Dissociative episodes can be triggered by any of the senses. If a person's body sensors detect impending danger, the mind can flee to a safer place. In some instances, survivors have reported losing memory for extended periods of time. Obviously, this can be a very frightening experience.

The following case study will illustrate how dissociative episodes can occur, and how the origin of these episodes can be identified to ease the victim's stress. "Mary" is a pseudonym for this survivor.

Mary frequently would try to harm herself by taking drugs or cutting her arms with sharp objects. She thought she was going insane. Mary became increasingly frightened by her feelings. On her counselor's advice, she wrote about her experiences.

With her counselor's help, Mary came to realize that just before she harmed herself, she was frying meat. When all the pieces of the puzzle came together, Mary's counselor determined that when Mary was 12, she was maltreated by her father in the kitchen where meat was being fried. The smell of meat frying created dissociative episodes that precipitated her self-destructive behavior.

When a survivor is under extreme stress, the probability for experiencing a dissociative episode increases and the episode may be more intense. The presence of a child with a disability can produce a level of stress that may trigger a dissociative episode in some individuals.

Ignoring dissociative episodes can have tragic results. A survivor who does not understand dissociative episodes — when no one can explain what is happening, why it happens, and what is necessary to stop it from occurring — may attempt suicide. Experts stress that professionals who are not specifically trained to work with problems or issues faced by adult survivors should refer them to someone who is.

Self-abusive, self-destructive behaviors

Living in an abusive environment can produce behaviors that help an individual survive in the short run but can be self-destructive. Sexual victimization can create a sense of numbness, extreme emotional pain and a sense of living in an unreal world. Some victims respond by engaging in self-abusive behaviors, such as excessive use of alcohol or drugs, suicide

attempts that call attention to one's pain, or self-mutilation. Victims might cut their bodies, burn themselves with cigarettes or pull out their hair.

Survivors say they do these things for many reasons:

- To take charge of their bodies and create a sense of identity independent of the abuse.
- To attempt to end flashbacks or a dissociative episode.
- To give themselves a sense that they are real or alive, especially if they feel that part of their body is dead as a result of the abuse.

The fact that survivors would cut or burn themselves to bring an end to a dissociative episode is graphic testimony to the intense emotional pain they are experiencing.

Many survivors are ashamed of the behaviors and experiences. It is important to encourage them to seek professional counseling. Some of these occurrences surface because of a lack of impulse control and heightened anxiety. Much of the self abuse occurs because survivors did not receive adequate intervention when they were children. As adults, the pain persists. These individuals need help to learn additional healthy coping mechanisms.

In therapeutic settings, it is common for counselors to create a safety contract with survivors who self-mutilate. The counselor asks survivors to write down alternative activities they can do rather than harm themselves. The counselor then follows up to determine if the survivors practiced these alternatives and if they worked.

It is critical that survivors who commit self-destructive acts be referred to professionals experienced in treating such behaviors.

Self mutilation: Characteristics of survivors

John Briere in *Therapy for Adults Molested as Children, Beyond Survival*,[3] described characteristics of the survivors he has counseled who have attempted self-mutilation.

- Survivors turn their conflict inward, thereby punishing themselves rather than others for their abuse-related pain.
- Survivors often describe a period of escalating guilt, self-criticism and increasing self-loathing before injury, leading to an overwhelming desire for punishment. After inflicting self-injury, there is usually a period of calm—even relief.
- Survivors with suicidal tendencies may report an ongoing preoccupation with dying and death, usually resulting from feelings of helplessness, hopelessness and a combination of anger at self (for being so weak, disgusting, stupid, etc.) and others (for not caring, loving, supporting, etc).
- The survivor who self-mutilates is crying for help and struggling to stay alive. The survivor who attempts suicide does not perceive any other option.
- Self-mutilation is often an attempt to block or interrupt negative thoughts or feelings and thus may be an attempt to survive incapacitating symptoms rather than ending life.
- Some survivors may be rehearsing for the real thing: suicide.

Depression

Research suggests that child sexual abuse victims are far more likely than non-victims to experience depression as adults. Depression is commonly reported among adults who were sexually abused or sexually assaulted in their childhood.[4]

Among the research findings:

"[There is] an even greater lifetime risk for major depression among women molested as children (21.9 percent for those molested vs. 5.5 percent for those with no history of child abuse)."[5]

". . . child and adolescent psychiatric outpatients with sexual abuse histories were more than four times as likely to receive a diagnosis of major depression."[6]

Maternal depression also contributes to the risk of child abuse and neglect. Depressed mothers, for example, may show little interest in the emotional or physical well-being of their children. For infants to develop a secure attachment, mothers must nurture them and respond sensitively and consistently to their crying and other attention-seeking behaviors. Mothers need to be flexible in order to accommodate disruptions in their daily schedules due to the persistent and sometimes complex needs of their babies. They need to play with and talk to the baby; they need to understand and use appropriate, non-aggressive techniques of discipline; they need to be able to distinguish the child's needs from their own; and they need to promote a harmonious environment.

When the mother does not provide sensitive and consistent care, the infant's development will likely be affected in an adverse way. A depressed mother's ability to respond appropriately to her baby is often seriously limited. Among depressed adolescent mothers, who may have a limited understanding of their role in the infant's development, the impact may be even worse.

The possibility of post-partum depression should also be considered. Post-partum depression affects 10 to 20 percent of women and can occur in a mild-to-moderate degree. There are specific factors that put women at higher risk for post-partum depression. They include:

► Father or partner does not assume parenting responsibilities to an adequate extent

Assuming the role of a parent is a major adjustment. When both partners in a relationship share the additional responsibilities, the adjustment is significantly easier. If one party does not take on sufficient responsibility, marital tension can result and this may affect the relationship between the mother and infant.

► The new mother had a poor relationship with her mother

When a new mother rejects her own mother's philosophies in child rearing, she may be left without a role model. She knows what she doesn't want to do, but needs help in determining what she should do. This can produce feelings of isolation, frustration and the inability to cope with her situation.

► Absence of extended family and friends

New mothers are more prone to anxiety and depression when they do not receive assistance and support from others.

► Mismatch between the mother's and infant's temperaments

If neither the mother nor infant can read the other's cues, satisfaction for both can be impaired. The mother, for example, may not be able to distinguish the different cries from her baby, and the result is that she responds inappropriately. Another example is the mother who repeatedly picks up her baby to cuddle it, but the infant wants time alone.

► Stressful environment

Stressful events such as the death of a loved one, moving out of the community, or job loss by either parent, place a new mother at high risk for post-partum depression.

► Pre-existing psychiatric disorder or family history of such disorders[7]

Depression can be treated and overcome. Problems occur when symptoms of depression are overlooked or unrecognized. When a parent

Manifestations of depression

When a person's self-image becomes persistently negative, depression may result. Some of the manifestations of depression are:

- ✓ poor appetite
- ✓ sleep disturbances
- ✓ less interest in, pleasure from, usual activities
- ✓ feelings of worthlessness
- ✓ loss of energy
- ✓ self reproach
- ✓ decreased sex drive
- ✓ impaired concentration
- ✓ excessive or inappropriate guilt
- ✓ suicide attempts

Post-partum depression

Working with new mothers

Once post-partum depression is recognized and treated, mothers can be helped to have a much more satisfying relationship with their children. Suggestions for working with new mothers, offered by P.N. Harberger in *Post-partum Psychiatric Illness*,[8] are:

Suggested strategies

1. Expect a disaster to occur.
2. Create a safe environment for the mother to express her feelings.
3. Ask open-ended questions about the mother's feelings about motherhood.
4. Listen for coded or underlying messages. The mother may seek help for her baby in an effort to find help for herself.
5. Communicate hope. Motherhood is by no means magical. Many women do not believe they have the skills to care for their children.
6. Refer appropriately. Referral in time when post-partum depression needs additional attention is crucial. The earlier it is diagnosed, the better.
7. Provide close follow-up. With so much attention focused on the child and the new family, it also is necessary to closely monitor how the mother is doing as the child goes through different developmental levels.

Examples and responses

1. The baby is allergic to breast milk or the mother is unable to breast feed.

   Help the mother understand and accept that the baby will be fine with formula.

2. The mother is exhausted because she has to get up so often during the night and has difficulty getting back to sleep.

   Acknowledge the difficulty of her situation by saying something like, "It sounds as though this has been a tough week for you. Let's talk about it."

3. The infant cries for extended periods of time and there is no apparent reason for this.

   Ask the mother how she felt when she couldn't get the baby to stop crying.

4. The mother makes frequent visits to the doctor to have her baby checked but there is no real need for many of these visits.

   Ask the mother questions about how she is feeling — both physically and emotionally.

5. The mother is feeling overwhelmed because she almost dropped her baby while giving it a bath.

   Provide reassurance that no matter how hard we try, we all make mistakes. We have to keep trying and not be too hard on ourselves.

6. The mother expresses exasperation at how difficult parenting is and that she simply doesn't know the right things to do.

   Try to arrange for a public health nurse or staff from in-home nursing services to visit the mother at home and help instruct her in some basic areas.

7. The baby has Down Syndrome and the mother is exhausted from responding to the child's special needs.

   Ask the mother questions about herself and how she is feeling. Let her know you are interested in her well-being.

says, "I am a bad mother" or "My baby hates me" or "I don't know how to be a mom," this should not be ignored. Family, friends and the mothers may unrealistically expect motherhood to come "naturally." If mothers are embarrassed about their lack of knowledge and cannot verbalize their fears and concerns, depression can result.

When a mother learns her child has a disability, it is common for her to experience some level of depression. Sometimes the mother's own feelings should be addressed before she is given detailed information on the resources most critical for her child's disability. If resource information is provided to a mother too early — before she is ready for it — she may not be able to adequately process it or even remember it. Some mothers, however, prefer the information first and then deal with their feelings later. It is important that service providers are prepared to respond to the individual needs of each parent. In an ideal world, resources would be easily available and accessible to those who need it the most. Unfortunately, reality rarely corresponds to the ideal.

Shame

There is a distinct difference between guilt and shame. Guilt is a regretful feeling about one's behavior. Shame is a deeply regretful feeling about one's self. "To feel shame is to feel nakedly exposed to the world, unprotected from critical eyes."[9]

Both guilt and shame create emotional discomfort. A person feeling guilt will be embarrassed, sad or remorseful and, as a result, may change future behavior. A person experiencing shame will feel inadequate, deficient, worthless, disgraced and exposed. She will not know how to cope with feelings of shame.

Feelings of guilt can be healthy and functional. They are the natural response when our behavior deviates from our values. There are ready solutions to feelings of guilt: we either change our behavior or change our values. Feelings of shame are never healthy because they are all-encompassing and do not make a distinction between specific behavior and total self.

Many feelings of shame are initiated in childhood. Parents who tell their children, "You are no good," or "You are an evil child," induce feelings of shame. In contrast, parents who point to specific behaviors that are unacceptable (such as hitting another child, getting a bad grade or not going to bed when they are told) induce guilt. The child who feels guilt can get rid of it by changing his or her behavior. The child who feels shame has no such recourse.

Adult survivors frequently experience shame because the act of victimization to which they were subjected was so shaming. Adult survivors may feel unworthy because everything they tried as children to right "their" wrongs did not work. They wound up feeling both unloved and unlovable. As children, they wanted to escape from the day-to-day realities of their maltreatment but they also greatly feared abandonment by the very people who were abusing them.

Feelings of shame take a long time to heal. According to a prominent psychiatrist, "If a child lives a childhood of shame, he or she can spend an adulthood unliving it."

As a means of coping with their low self-esteem, many adult survivors create an "ideal self." They attempt to be perfect. When they do not succeed, they re-experience feelings of shame. People experiencing shame feel extremely vulnerable and spend considerable time and energy trying to feel safe. They may demonstrate rage and hostility to keep others from seeing how truly exposed and worthless they feel.

Adult survivors who experience feelings of shame usually benefit from professional counseling and support groups. "Damage from shame begins to heal when that shame is exposed to others in a safe environment."[10] Before survivors can move forward, they must be treated with respect. They need reinforcement as they learn to distinguish between their specific behaviors and their total selves.

A person subject to feelings of shame often is incapable of maintaining perspective when her behavior is criticized. For example, a woman is late to an appointment at a county assistance agency and the

worker responds with a reprimand. The woman may revert to a shame-based response, such as not returning to the agency even though it may be the only place that can give her the assistance she needs. Instead of feeling guilty for being late, the woman feels completely worthless and then tries to protect herself.

Adult survivors who have not worked through their feelings of shame can be doubly affected when they have a child with disabilities. Parents often experience feelings of guilt when they learn their child has a disability. "Did I somehow cause it?" or "Am I being punished for some past bad behavior?" are typical questions parents ask themselves. A survivor with feelings of shame will not ask these questions but rather isolate herself and feel certain she is to blame.

Having shame-based feelings can be an encompassing, disabling condition. It deprives a person of perspective and causes over-reaction to the normal criticisms, mistreatment, misunderstandings and inconveniences we all normally experience on a daily basis. A parent feeling shame may not be capable of adequate parenting, so consumed is she by the need to first protect herself.

An intervention strategy

When working with survivor parents whose children have disabilities, it is constantly necessary to focus on strengths. A positive, building attitude can have major consequences for how parents integrate their children into their daily lives.

The following factors have been cited as critical approaches or strategies that may help parents adjust positively to the news that their child was born with disabilities.

❶ Assistance is offered that responds to the specific problems the parents are experiencing.

The reality of their child's disability comes as a blow to new parents. Their immediate feelings of sorrow, fear and anger can interfere with their ability to bond with the child.

Ideally, the family will receive immediate support and information to help them through this crisis. Comprehensive services would be an appropriate treatment response. Optimally, this should include counseling to facilitate the parents' need to express grief, and support to assist them in adjusting to the unique and unanticipated needs of the child with a disability. These services would also help the parents see beyond the child's disability or chronic illness and value the child for who he or she is.

Sometimes professionals have a fixed formula for working with parents. They lose sight of each family's unique qualities. While there are some commonalities, each family needs to feel that their concerns are being heard.

❷ At the time of diagnosis, the family receives:

- ► A skillful and sensitive response by an informed professional or team of professionals, including at least one person they already know;
- ► Easy access to helpful information about their child's diagnosis, such as a framework for realistic expectations, ability to answer questions, explanation of the disability and a description of services.
- ► Information that emphasizes their child's strengths and that promotes a positive posture.

❸ Parents are provided information on parent support groups, parent organizations and agencies that provide follow-up services and assistance. Parents should be strongly encouraged to follow up on these sources.[11]

Parents who have just learned that their child has a disability need support and reassurance to look beyond short term disappointment and fears. Once they receive the assistance they need, most parents will be able to make a positive adjustment and discover a love with deeper roots than they ever thought possible.

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Family Designs

Risk factors in child maltreatment

There are numerous articles and studies available to professionals that describe the risk factors for child maltreatment in families. The question is, "How can professionals use these resources to effectively reach families before maltreatment occurs?"

Chapter One discussed how risk factors affect family functioning. This chapter will consider alternative family designs and how they relate to risk factors in child maltreatment. It is important to remember in reading this chapter that families who have children with disabilities may experience an additional layer of stress because of the children's unique needs.

Common characteristics of healthy families include flexibility, a sense of wholeness, access to adequate child development information, the

What is known about strong families?

There is a substantial amount of information available on the family characteristics that promote healthy functioning. In *Secrets of Strong Families*[1], Nick Stinnett and John Defrain identify six qualities of strong families:

1. Commitment — Family members believe in each other's worth and value the family unit.
2. Appreciation — Family members are able to let others in the family unit know their worth.
3. Communication — Individuals in families are able to communicate with each other, enjoy spending time together to talk, and are involved in each other's lives.
4. Time — Family members set aside quality time for each other.
5. Spiritual wellness — This does not have to mean a specific religious belief, but rather a belief that there is a good and higher power that affords them strength and purpose.
6. Coping ability — Individuals in the family are able to see distress and crisis as opportunities for growth.

Robert Hill in *The Strengths of Black Families*[2], identifies five characteristics that help black families survive, develop and remain stable:

1. Strong kinship bonds
2. Strong work orientation
3. Adaptability of family roles
4. A strong desire for achievement
5. Strong religious orientation

freedom to join together or to work independently, the ability to deal directly with all family individuals, a sense of belonging, respect for family elders, the freedom to show affection for each other, resiliency, the establishment of clear rules, and a sense of community.

Illustration by Martha Perske

Alternative family designs

The family design as seen on "Father Knows Best" or "Ozzie And Harriet" was considered the norm for American families in the 1950s. This family consisted of a husband and wife in their first and only marriage, who bore and raised their biological children.

Alternative family designs are becoming increasingly common and more visible in the United States. Examples of these include single-parent families, step families, foster families, adoptive families, and gay and lesbian families.

Some of these family designs are more at-risk for having a child that has been maltreated. Foster and adoptive children were more likely victims of maltreatment in their birth families. This means that foster parents and adoptive parents (especially those who adopt older children) must be more alert to signs of past maltreatment so they can respond appropriately and effectively.

Single-parent families and step families may experience additional stress due to family transitions that could put the children in these families at increased risk.

Single-parent families

Sylvia Ann Hewlett compiled facts about what is happening to the family in America[3]:

- Half of all marriages end in divorce.
- The single-parent family is today's fastest-growing family design. The percentage of children living in single-parent families has doubled to 25 percent in the past 50 years.
- Six households are headed by single mothers for every one headed by a single father.
- Forty-one percent of absent fathers do not pay child support. Nationwide, divorced fathers owe $4.6 billion to their children.
- About half of all single mothers are living below the poverty line, compared with one in 10 married couples.
- Between 1970 and 1989, the number of mothers who work more than one job increased five-fold.

Stress can become overwhelming for any single parent. That parent (typically the mother) has primary or sole responsibility for raising the children, cooking, shopping, doing the laundry and cleaning. Many of these mothers also work full time. When the fathers are not paying child support, often there is not enough money to meet the family's basic needs. Mothers must sometimes move their families to low-cost housing in unsafe neighborhoods, creating a whole new set of problems and adding to the stress.

Risk of maltreatment is increased when there is turmoil between divorced

parents, when there is inadequate child care and the lack of respite for the parent, when children have chronic emotional or behavioral problems or physical disabilities requiring a disproportionate amount of time and attention, or when the family is isolated.

Step families

Many divorced parents remarry, creating a new family structure — step families. The term "step families" refers to two situations: 1) blended families in which each parent in the new marriage brings children from a former marriage, and 2) families in which only one parent in the new marriage brings children from a previous marriage.

The step-family structure may provide additional support to the children and parents, but it also presents challenges. Step families often have children who aren't related to each other, more grandparents in the family unit, varying discipline practices, issues of loyalty to absent parents, issues of authority from the non-birth parent, as well as new surroundings and routines.

Children gain a sense of stability and order from traditions. When families are blended, traditions are often lost because each previous family had different traditions. Some examples of traditions that are very important to children are: holiday celebrations, birthdays, vacations and weekend rituals. New traditions for the blended family need to be created.

Societal myths may predispose the children to judge step families as good or bad. Some of these myths are:

- Stepparents are cruel.
- Everyone in the newly created family will immediately love and care for each other.
- A step family formed after the death of a parent will not have as much trouble as one formed after a divorce.
- The new family can easily function with the same rules as the previous families.

The reality is that the new situation is different, not necessarily good or bad. The degree of adaptation to a new family system is dependent on how comfortable those involved feel with it. Some level of pain is normal in a radically changing family situation. A child, for example, may believe that he or she caused the divorce in the previous relationship, especially if there has been a high level of stress between the parent and child and/or this stress has not been resolved; a child may resent the parent who initiated the divorce; a child may not accept the new non-birth parent; or the child may simply deny that the family unit has changed.

All children in the previous families need to deal with their sense of loss in the breakup of the old family before they are ready to accept the new family. Children might feel sadness but not talk about it or even understand their own feelings. Children may not be aware of or comprehend the full extent of the problems their parents had. A chemically dependent parent or a violent marriage are confusing to a child. If children are unable to express the pain and loss they feel, this will be a barrier to creating healthy, new relationships.

When a blended family has a child with a disability, the adjustment challenge can be even greater. It can take a long time for the new step parent to bond and to be able to properly care for the child. It may also take special efforts to familiarize stepbrothers and stepsisters with the special needs of a child with a disability. The presence of a child with a disability may create resentments about a new "burden" in the family.

When children view the stepparent favorably, they have the opportunity to benefit from a new perspective and have new, positive experiences.

Healthy step families can result when the new couple does the following:

- Clearly states family rules.
- Establishes new traditions and rituals for the family that give children something to rely on and look forward to.
- Creates an environment in which angry feelings can be talked about without fear of punishment.
- Meets problems head-on and discusses them openly. Ignoring negative behaviors only precipitates a crisis.

Moving from unrealistic to realistic expectations

In a step family, it's important for partners to recognize unrealistic expectations and replace them with realistic expectations. This chart, from *Strengthening Your Stepfamily*[A], points out the positive effects such changes can have on the feelings and outlook of all step-family members.

Unrealistic expectation	Underlying hope	Resulting feelings
"We will all love one another."	*To be a happy, harmonious family.*	Guilt when love doesn't occur quickly.
"Life in our former families won't matter."	To forget the past and make a fresh start.	Isolation from each other; fragmentation of parts of ourselves.
"We'll do it better this time around."	To make up for the past sadness and loss.	Disappointment in our new family when everything doesn't go smoothly.
"We will and must function smoothly as a family."	To present a picture of family unity to friends, families, outsiders.	Frustration and discouragement about all the differences to be resolved; defensiveness about how outsiders see us.
"Everything will fall quickly into place."	To find immediate success and happiness as a stepfamily.	Fear that new marriage is failing and that this family might end.
"Our children will feel as happy about the remarriage as we do."	To give children security and stability.	Resentment toward children for not being happier, toward one another for being somehow to blame.
"Our stepchildren will respond readily to our efforts at discipline. Discipline will not present difficulties for us as a couple."	To have a positive effect on children's lives.	Anger that comes from division about rules, responsibilities, acceptable behavior, and discipline techniques.

Realistic expectation	Resulting feelings
"Love may or may not develop later; what's important is to accept and respect each other."	Satisfaction and comfort among stepfamily members.
"Differences in our backgrounds will be part of our daily lives. We will all need to deal with these, and we can all grow because of them."	Connection to, and pride in, the past; optimism about enriching one another's lives in the future.
"This new family will be neither better nor worse - it will simply be different."	Excitement at the prospect of building this special family together.
"All stepfamilies have difficulties and differences to work through. Presenting a polished picture to outsiders is not important."	Relief to know others face similar problems; greater ease in working to build closeness and understanding.
"Becoming a stepfamily takes time; satisfaction comes from working together to build that family."	Confidence that we can build a strong stepfamily, satisfaction in the gradual progress we make; less discouragement when obstacles and setbacks occur.
"Children will feel confused — both happy and angry — about the remarriage; they had no choice either in the ending of their first family or in the forming of this new one."	Empathy and responsiveness in dealing with the children in our stepfamily.
"Many children, teenagers especially, will be unwilling to accept authority from stepparents. Adults won't automatically agree about how to discipline."	Less resentment or sense of threat, more patience and willingness to compromise. Interested in building relationships rather than wielding authority, in cooperating rather than competing with spouse to do this.

- Allows adequate time for the new relationships to develop.
- Allows children to participate in some decisions in the new family, such as in choosing family activities.
- Openly discusses personal boundaries, especially as they may relate to sexuality.
- Sets aside specific time to have fun together, both within the adult relationship and among the new family unit.
- Uses large doses of patience.
- Obtains help if either partner begins to feel overwhelmed.
- Creates situations in which family members are comfortable with compromise rather than taking sides.
- Allows each of the children to have their separate things; does not insist they share everything with new family members.
- Expects the children in the new family to react negatively at times and understands that such a response is normal.[5]

Stress for step families

Blended or step families may face circumstances that present unique sources of stress. Some examples of these circumstances are:

- **A new stepparent has no parenting experience and/or lacks sufficient information about the stepchildren necessary for making quality decisions.**
- **A stepparent must make difficult medical decisions in the absence of the children's birth parent. This is a critical issue in step families that have children with disabilities.**
- **Parents lack understanding or insight into ways to create a strong, new family.**
- **The new family has a child with a disability and the stepparent has uninformed or unrealistic expectations of what is involved in caring for that child. The stepparent does not have an understanding of the potential or significant loss of freedom that results from responding to this child's special needs.**
- **Parents side with one child against another in a newly blended family.**
- **Parents ignore temper tantrums and arguments between birth siblings and stepchildren in the hope they will resolve themselves without discussion or work.**
- **A new place in the family is not created for any additional members.**
- **The roles and expectations in the new family are not clearly established. Each child in a family unit has a role to fill. Blended families may interrupt the birth order and role expectations the children previously had. This can produce feelings of anger, resentment, confusion and abandonment.**
- **Children feel they are in competition with the new stepparent for their mother's or father's attention.**
- **Adults in a blended family may not take sufficient time to develop their own relationship. When this happens, they will not be equipped to function as a team in responding to issues with the children.**
- **Stepparents do not give children "you belong" messages that make the children know they are a wanted, important part of the family.**

Children are often subject to numerous changes in their lives that affect their ability to form strong, healthy relationships. Current studies show that even with guidance and awareness of existing problems, nearly half of all blended families dissolve by the time the children reach adolescence. Research further indicates that Caucasian families dissolve more readily and remarry at a much faster rate; black families marry less often and remarry at a slower rate, although they experience more marital disruptions than their white counterparts.[6]

Foster families

Foster care occurs when parents are unable or refuse to care for their children. Foster care is designed to be short term, rather than permanent. It can be initiated by the parent

because of illness or other extenuating circumstances, but it is most often initiated by a child protection agency that found the parent was abusing and/or neglecting the children.

Two of the most common types of foster families are:

❶ Relatives of the children

Grandparents or siblings of the children's parents may take on the parenting role. This can happen when the children's parents have left or are incapacitated due to drug abuse, illness or other factors.

❷ Licensed families

Families are trained and licensed by a foster care agency and then await the arrival of children assigned to their home.

Other types of foster care are: shelter care, group care, therapeutic foster care, corrections care and respite care. In some cases, a teenage mother and her infant will be cared for together in a foster home.

Children with severe disabilities and who are medically fragile may be placed in specialized medical foster homes, staffed by nurses, until the birth parents are ready to care for them at home or until other arrangements can be made.

A number of issues have emerged in foster care. One of these is "kinship placements" that try to ensure that children of color are cared for by other family members. Another issue is placing children of color with families of the same race.

Whatever the type of home or the reason for the child's placement, foster care is supposed to provide out-of-home care for children until they can be reunited with their birth or adoptive families. Foster care is the most common and least restrictive out-of-home placement in the United States.

There are a number of misconceptions or myths about the foster care system, including:

- ► Foster parents are mean, and foster homes are like jails.
- ► Foster parents make a good living from the stipend they receive.
- ► A significant percentage of children are abused and neglected in foster homes.
- ► Foster parents turn children against their families of origin and do not allow the children to go home when their families request visits.
- ► Foster parents cannot have children of their own and are not suitable for adopting children.
- ► Foster care is always temporary.

The foster care system is highly controversial, with many critics both inside and outside the system. Four of the problems cited are:

❶ Laws designed to protect the rights of the birth parents often do so at the expense of the children.

Although foster care was designed to be temporary, tragically for many children, it is permanent. Birth parents may refuse to relinquish their rights but also may be incapable or unwilling to care for their children. In practice, the children may stay in foster care until they are of legal age.

Even when parents relinquish their rights after the children are teenagers, it is extremely difficult to find

parents willing to adopt older children, so the children remain in foster care.

❷ Foster families sometimes are inadequately screened.

It is the exception rather than the rule, but when families with criminal or abusive histories are not screened out in the foster family selection process, the entire foster care system has a bad name and negatively affects public attitudes.

❸ Foster families are inadequately trained.

The lack of training is not an indictment of the foster families. Many children are placed in foster homes because their birth parents abused and/or neglected them. These children have special needs and, often, serious emotional and behavioral disorders. Parenting these children is a significant challenge and often requires sophisticated skills that the average parent may not possess. This is especially the case with children who have been sexually or physically abused or who have been in and out of many foster homes. Frequently, these children are unable to bond with foster families.

There are other special skills foster parents may need, such as being culturally competent if the child is of a different ethnic background, or understanding and responding appropriately to children with disabilities. Increasingly, foster children have seriously disabling conditions, such as fetal alcohol syndrome, or are prenatally exposed to drugs such as crack or cocaine.

Training for foster parents

Foster parents benefit from training in the following areas:

- **How to respond to children with extreme acting-out or destructive behaviors.**
- **How to respond appropriately to children who are victims of sexual abuse. This includes understanding how these children may misinterpret normal behavior and the importance of the foster parents establishing clear, appropriate personal boundaries.**
- **How to provide safe environments for abused children.**
- **How maltreatment affects child development and how to reverse those negative effects when it is possible to do so.**
- **How to provide encouragement and motivation to abused children to change their counterproductive behavior patterns.**
- **How to focus on the children's strengths rather than on the problems.**
- **How to provide appropriate assistance to children who have physical disabilities, learning problems or emotional difficulties.**
- **How to help children have successful home visits with positive outcomes.**
- **How the issue of family loyalty on the part of the child can interfere with the placement process.**

❹ The foster care system is outdated.

Criticisms abound here. Many believe the concepts upon which the system's policies are premised are outdated or ill conceived. Others charge that the entire system is vastly underfunded and as a result cannot accomplish the intended results.

One criticism leveled at the system is that there are contradictory expectations of foster parents who have children with disabilities placed in their homes. On the one hand, foster parents are asked to help these children and this can only be done with considerable love and special attention. On the other hand, the foster parents are expected not to become too attached to these children who ultimately may be returned to their birth parents.

Like the foster parents, the children also may be caught in a system that produces conflicts. They can feel abandoned first by the parents when they are placed in foster care and, later, by the foster parents when they are returned to their parents.

A variety of solutions to the above problems are being tried in various parts of the country. Characteristic of these new solutions is a concerted effort to prevent problems and to be proactive rather than reactive.

Some leading national organizations, such as the Child Welfare League of America, have examined how the foster care system — and, specifically, foster care parents

— can maintain a stronger and more solution-oriented focus.

New Mexico, for example, is embarking on a reform plan to train foster parents to be a part of a family preservation team. The idea is to promote children remaining in their natural homes while improving the skills of the birth parents. Methods will be developed for joint training of foster parents and social workers. The goal is to enhance family preservation and reunification efforts.

In Massachusetts, foster parents are being trained to provide intensive in-home services and support to families whose children are felt to be at risk for out-of-home placement. If relief care is needed for the children, the foster parents provide that care. This approach recognizes that: a) some families need one-to-one support in parenting and b) some children have such special needs that no one family can adequately respond. This approach also has the flexibility to provide services at times most convenient to the parents, i.e. evenings and weekends.

Other efforts to improve the foster care system focus on the training provided to foster parents. The University of Minnesota, for example, has designed a competency-based foster care curriculum. Foster parents are eligible to attend up to 60 hours of training each year. The types of training include: knowledge and understanding of the foster care system; family dynamics; improving self-esteem and self-concept; the effects of child maltreatment; cultural, ethnic and economic diversity; separation, loss and attachment; effective communication skills; nurturing; moving beyond survival; and unique and special challenges.

The University of Minnesota also sponsors a training of trainers program. Foster parents who have completed the competency program are provided instruction on how to train other foster parents. County social service workers use graduates of this program to conduct introductory sessions for prospective foster parents and to supplement county training activities.

While there are exciting, innovative efforts to overhaul or revise the foster care system, such efforts take time to be designed and implemented on the massive scale necessary to correct the problems in the current system.

Adoptive families: Special risks

It is difficult to believe that some prospective adoptive parents are still being given this message: "All this child needs is your love and a stable home."

It is well-documented that some of the most serious challenges in adoption are:

- Children who have already had multiple placements.
- Children with serious emotional or behavioral diagnoses.
- Children with other significant physical or developmental disabilities.
- Children who have been neglected or physically, sexually or emotionally abused.

Families who adopt children with special needs may require additional help and support. They need to have a thorough understanding of child development, a complete history of the child, knowledge of how the child's experiences can affect his or her world view, and information about where to go for help if problems begin to surface.

Knowing the nature of the problems a child has been exposed to is not enough. Adoptive parents need to know how the experiences may affect the child's entire life. Adoptive parents need a strong support system, and they need to meet other families who have adopted children with problems similar to the ones their child has.

Extended family members may support adoptive parents to a degree, but some children pose problems that the extended family hasn't faced and for which they are unequipped to respond appropriately.

Some families have adopted children whose disability or chronic illness diagnosis was not available when the adoption was finalized. They have adopted children without knowing the extent or significance of prior abuse, neglect or other chronic condition. Obtaining financial assistance to respond to these problems after an adoptionhas been finalized can be almost impossible in some areas of the country. Some families spend all their resources pursuing the appropriate care for the child.

Support and follow-up assistance to address medical, emotional or mental health problems are crucial to the well-being of adoptive families. Some families have terminated an adoption because of inadequate financial resources and support. Adoptive parents need to be aware of possible caps on their insurance policies for physical and mental health services, and the availability (or lack) of adoption subsidies.

Abuse suffered by an adopted child can be difficult to diagnose and treat. The child's history may not be known, or records have been lost. Adoptive parents sometime spend a lot of money on therapists in order to identify the cause of their adopted child's problems and how their family can respond to the child's needs more effectively.

Teen parents

Adolescence is a time for growth and development, but before many teenagers have matured emotionally, they become parents. The phenomenon of children having children has been steadily increasing in the United States:

- Every day more than 8,000 teenagers become sexually active and 1,340 teenagers give birth. About every minute, a teenage mother has a baby.
- In 1970 less than one-third of teenage mothers were unmarried. Today nearly two-thirds of teenage mothers are unmarried.
- Each year at least 40,000 teenage girls drop out of school due to pregnancy. Fewer than six of 10 adolescent mothers will receive their high school diplomas by age 29.
- Teenagers in the United States are twice as likely to become teen parents as teens in other industrialized countries.
- Almost half of teenage mothers do not receive early prenatal care.[7]

The outlook for many of the citizens of tomorrow is bleak. Child abuse and neglect tend to self-perpetuate unless there is timely, appropriate intervention. Too many teenage women are becoming parents before they are intellectually or emotionally equipped to raise healthy, well-adjusted babies.

The increased focus on early childhood programs has resulted in the demise of many programs for teenagers as funding has been shifted from one age group to another. The best that many communities have done is launch "Just say no to sex" campaigns. Meanwhile, more and more teens are becoming pregnant while being unprepared to be effective in the critical role of parents.

In the United States the topic of teenage sexual energies usually elicits feelings of discomfort and embarrassment. In other countries where the topic of sex is more openly addressed by parents and educators, the number of teen pregnancies is much lower than in America.

Frequently, teenage girls who come from abusive or neglectful backgrounds are motivated to have a baby because of their desire to be loved. They don't think of the baby as being a helpless infant whose needs must constantly be responded to; instead they think of a baby as someone who will love them. A baby is not seen as a responsibility as much as a solution to their own emotional needs. These unprepared mothers often wind up virtually overwhelmed by the reality of parenting.

The immaturity of teenage fathers is demonstrated by a general lack of financial or parenting support provided to their birth children. The child may be little more than the basis for "virility bragging" among their peers.

There are various personality characteristics that have an impact on teen pregnancy. In

John Mitchell's book, *The Nature Of Adolescents*[8], he identifies six that influence sexual expression among teens.

❶ Intimacy: Being sexual is a common way for adolescents to feel close to someone or feel they have a meaningful relationship. Television shows and films with highly romantic, unrealistic portrayals of relationships can have a powerful influence on impressionable youth.

❷ Belonging: To belong means a person has a place, a purpose. Wanting to belong is possibly the most pressing need of adolescents. In many circles, "belonging" requires being sexually active.

❸ Dominance and submissiveness: In the United States, male dominance is the norm. Girls who, for whatever reason, have not formed an identity strong enough to stand up to this belief often are prey for males who desire sex.

❹ Competence and curiosity: When teens are not given much information about sex, they become more curious. Sexual expression is seen as an adventure, something to conquer. Competence then becomes a need to conquer sexual expression. The myth that "you are not a man until you have sowed your oats" further sets the stage for teenage boys to experiment sexually.[9]

❺ Passion and intensity: Feeling intensely passionate with another individual is to feel — at least temporarily — loved. This is a high attraction to teenagers who want to feel both strong emotions and a feeling of being appreciated. This can become even more ingrained in poverty-ridden communities, where young people are willing to do anything to escape the stark, negative realities before them. Thinking about sex and sexual expression is also a way to feel powerful, to feel a sense of mastery. It signifies to teenagers that they are now adults and this is a very appealing way to explore adulthood.

❻ Rebelliousness and negative identity: A mother says, "If I really want my teenagers to do something, I know to tell them to do the opposite. That way I will be sure to get what I want." Children who have not had a place of power in their lives, whether it is in their families, schools or communities, often rebel to establish an identity that is contrary to their surroundings. In many cases, sexuality becomes the issue on which to wage battle.

Reaching today's teenagers

In addition to offering information and support that may help to reduce teen pregnancy, we need to assist teens who are already parents. Programming issues include availability, accessibility, appropriate program design, and coordination of services.

Availability: Among programs most needed are parenting education and support, education on special issues for children with disabilities, child care services, vocational assessment and training, health care services and safe housing accommodations.

Accessibility: The location, days and hours of the programs must be appropriate to young people in school who also have the responsibilities of parenthood. Transportation and day care needs are major barriers to teens participating in programs.

Appropriate program design: Teenage parents need to be motivated to participate in programs that require additional time and energy. Giving them school credits for a parenting course and integrating that course into the high school curriculum, for example, may make the class more appealing and increase attendance.

Coordination of services: Integrating and coordinating programs can be accomplished in several ways, such as inviting agency representatives into a parenting class to desribe their services to the teens, or physically taking the mothers to the resources as part of the curriculum. Brochures on agency programs can be given to teens and the information reviewed in parenting classes. Teenagers need to be advised of eligibility requirements and other restrictions before they contact the agency. There could also be carpooling and pooled childcare so several teens can go to the agency together.

Extended families as a resource

In the past some societies were based on the tribe, the clan, and the extended family. While some cultures have continued this tradition, it is not true for all. In the United States, many families lack the support of an extended family. Some data reveal that the average family moves nine times during their lifetime, and these moves often result in a geographical separation from the extended family. While younger adults typically relocate for jobs, their parents often relocate upon retirement. One study shows that only 5 percent of children see their grandparents regularly.[10]

Americans who are separated from their extended family often feel a profound sense of loss. One family reflected, "We had no idea what we would miss when we moved away from extended members of our family. We wanted to get away from all the advice-giving and having others tell us what we needed to do. The problem is, we've had no resources to put in its place."

This loss can be even greater when parents are divorced. The custodial parent can easily feel overwhelmed without the help, support and sense of belonging provided by family members.

Many foster and adoptive parents speak of isolation and loneliness. This sometimes occurs because relatives do not understand the choice to adopt or care for a foster child. Some families simply will not accept a child who is not related by blood.

Children who have grown up drifting between foster homes speak of the emptiness and grief they feel at not having an extended family. When they become young adults and are ready to have children, they may feel a sense of rootlessness. There is no one person they can go to who will have all the information about what they have experienced and who can guide them in this difficult decision.

Families who have children with disabilities are in particular need of support from extended family members. Sometimes this support is not forthcoming because of the grandparents' lack of understanding about the disability. There may be no opportunities to learn about the disability in a comfortable setting. This is a problem that often can be solved.

For example, the Parent Advocacy Coalition for Education Rights (PACER Center) hosts a grandparent education and support group. This program helps grandparents of grandchildren with special needs understand the disabilities as well as their own feelings about them. The program empowers grandparents so they can provide appropriate support to both their children and grandchildren.

The reactions of grandparents to the PACER program have been extremely positive. Some of the grandparents' comments included:

"This was exactly what I had been looking for. It was the only time I felt really comfortable talking about my grandchild."

"The support group helped me get out of the closet. Now I realize I am not the only grandparent whose grandchild has a disability."

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Child Neglect

The impact on family functioning

The National Center on Child Abuse and Neglect concluded in a 1988 report that 63 percent of child maltreatment cases were due to neglect. Neglect occurred at twice the rate of physical abuse.[1] Another study found neglect to be present in half of the child abuse cases involving severe harm or death.[2] A University of Minnesota study reported that neglected children had "more varied and more severe problems than children in other groups."[3]

Illustration by Toni Parrish

There is not one standard definition of neglect; instead, each state has its own definition of what constitutes neglect. In Minnesota, for example, neglect is defined as:

- Failure to provide necessary food, clothing, shelter, education, or medical care when reasonably able to do so.
- Failure to protect a child from conditions or actions which imminently and seriously endanger the child's physical or mental health when reasonably able to do so.
- Medical neglect which includes, but is not limited to, the withholding of medically indicated treatment from a disabled infant with a life-threatening condition.[4]

There are a number of theories and observations about parents who neglect their children[5]:

- Neglectful parents may lack the capacity to love.
- They may be less aware of or open about their feelings.
- They may have a greater tendency to block out pain and to respond impulsively.
- They may experience phases of passive inactivity and numb hopelessness.

When parents lack skills and abilities, they are at greater risk for neglecting their

children. Parents may have more difficulty adequately coping with their role as a parent when they have these characteristics:

- ► An inadequate education
- ► Mental health problems, such as depression or low self esteem
- ► Lack of basic parenting and problem solving skills
- ► Mental retardation
- ► Substance abuse[6]

These parents may experience more stress and have fewer skills to cope with that stress. A mother who lacks basic parenting skills, for example, might use inappropriate disciplinary techniques. She might yell at the child or punish the child physically, and then experience additional frustration when these techniques are ineffective. A father who is depressed because he is unemployed loses perspective and stops interacting as a parent. Instead, he is overwhelmed by his personal problem of no longer being the bread winner. A mother who is cocaine dependent might escape by using the drug and, in the process, pay little attention to her children.

There is great potential for families to get ahead when intervention services include vocational and skill identification training, pre-natal counseling and medical care, mental health screening and chemical dependency assessment and treatment. The critical factor, however, is to anticipate that these other services are needed.

Characteristics of neglectful families

Eight characteristics of neglectful families were identified by Robert Hartley in *A Program Blueprint for Neglectful Families.*[7] They are:

1. **An extended-family history of neglect**
2. **The absence of positive support externally experienced by the families**
3. **The absence of a secure parent-child attachment**
4. **Low ego strength and low self esteem**
5. **An overdependence on service-delivery systems**
6. **The lack of normal child development**
7. **Chemical abuse**
8. **Transference of the attitudes and feelings of the families to the people assigned to work with cases of neglectful families.**

When parents lack knowledge and abilities, a vicious cycle can occur. Their inability to solve routine problems creates additional stress, and they are ill equipped to deal with that stress. When they feel too much stress, they either blow up or escape. Neither response helps the children or the parents.

Parents who lack inner resources need more assistance from others. They need guidance, support and respite care provided by an extended family, friends or community agencies. A capable, loving extended family could help them through a "tough time," but often their family is geographically removed or does not function well and only adds to the problem. There may be community resources that could help these parents, but they may not know of them, know how to access them, or trust them enough to use them.

There are a number of approaches that can be taken to respond to the incidence of child abuse and neglect. The three most important are: a) prevention, b) additional services to families, and c) a revision of the mix and style of services to families.

Prevention of child maltreatment

Statistics document that, on average, abused and neglected children do less well in school, are less likely to finish high school, are more likely to have behavioral problems and are more likely to be involved in the juvenile justice system. These statistics are part of the impetus for welfare reform within individual states and on the federal level.

Some critics say the availability of welfare reinforces negative decisions by young teenage women having babies they cannot adequately care for. The arguments include debates about not increasing monthly allotments for mothers on welfare who have additional children, mandating that unmarried mothers on welfare who are under 18 continue living with their parents, and holding parents of young mothers on welfare accountable for their daughters' school attendance.

Discussion about welfare reform appears to no longer be the classic conservative versus liberal debate about government spending. There is concern from a variety of groups, such as school teachers, parents of children in the public school system, child protection and other social service staff, police, the courts and correctional institutions. While there are different theories as to precisely what changes should be made, there is agreement that far too many children are abused and neglected.

Current trends dictate that changes will likely be made in the welfare system. The goal will be to facilitate more responsible decisions by young teens who do not possess necessary skills or have the knowledge to effectively parent. However effective these revisions may be in the future, today there is still concern for families who lack the necessary skills to care for and guide their children.

Illustration by Martha Perske

Additional services

Some government and social service agency personnel continue to make the case for additional services to parents who have inadequate resources to successfully meet the challenges of parenting. According to some analysts, the probability of this occurring on a significant scale appears to be minimal. The reasons they state include: evidence of the existence of poverty cycles and several generations in many families who are dependent on public assistance, the size of the national debt and the realignment necessary to shift a major funding focus, and the necessity of major revisions in the nation's priorities.

Still others see change happening with the current administration, such as the focus on health care, a focus on preventative versus reactive programming, and the increase in funding for Headstart and other early childhood services.

Revising the mix and style of services

Some government policies and bureaucracies produce rigid, inflexible responses that frustrate families and the professionals trying to assist them.

One example is a joint home visit by a county caseworker and a social worker from a school to a family with whom they each were working. They

How family support differs from traditional services

Overly rigid rules often preclude a simple, appropriate response. The Children's Defense Fund[7] shows how "family support" differs from "traditional models" on which many of the systems that work with families are based.

Family Support Services	Traditional Services
Help to prevent crisis by meeting needs early.	**Intervene after crises occur and needs intensify.**
Offer help meeting basic needs, special services and referral.	Offer only specific services or treatments.
Be flexible to family and community needs.	**Program and funding sources dictate services.**
Focus on families. Build on family strengths.	Focus on individuals. Emphasize family deficits.
Reach out to families. Offer drop-in services	**Have strict eligibility requirements. Have rigid office hours.**
Respond quickly to needs. Offer services in families' homes or home-like centers.	Often have waiting lists. Have office-based services.

found two of the mother's three small children crying and in very soiled diapers. The county caseworker stated the children needed to be removed from their home and placed in foster care. The school social worker believed that decision was not warranted and was very costly and ineffective solution. She suggested, instead, that they purchase a supply of diapers, then help the mother to understand where and how she could get diapers in the future when she runs out. The social worker from the school helped the mother enroll in a parenting support program available through community education, used scholarship money to pay for the program and guaranteed the county caseworker she would periodically check back to make sure the children were being well cared for. After working together to establish a level of trust, the mother and the school social worker maintained a cooperative relationship.

Policies in the social service system frequently do not offer county social service personnel the flexible funding that professionals could use for preventative work with families. However, several demonstration projects are underway nationally that will provide the service system with information and data on how this type of intervention works and the benefits to families.

The societal basis for neglect

Larry Brendtro in *Reclaiming Youth at Risk: Our Hope for the Future*[9] identifies a number of ways in which today's society actually may perpetuate neglect. Brendtro begins by pointing to centuries-old American Indian traditions on attitudes and treatment of children.

Indian children were highly valued. When parents were unable to care for their children, the clan or tribe would take over the role of teaching them to be a contributing member of the community.

The principal theories of the Indian communities on child development and creating healthy self esteem are quoted below. These same principles can be employed to empower families currently trapped in a cycle of neglect.

a) "Significance is found in the acceptance, attention and affection of others. To lack significance is to be rejected, ignored and not to belong."

Many individuals and families do not have a place in

our communities. They do not receive acceptance or nurturing. The predominant culture has not promoted their significance or created a sense of purpose from which they can grow to be contributing members in their communities. Isolation is a key issue to address when developing programs to break the cycle of neglect.

b) "Competence develops as one masters the environment. Success brings innate satisfaction and a sense of effectiveness while chronic failure stifles motivation."

Policy has not kept up with providing the necessities to make it possible for the family to work toward growth and health. Child care, transportation, safe housing and adequate incomes are some of the basic needs many families cannot meet.

c) "Power is shown in the ability to control one's behavior and gain the respect of others. Those lacking power feel helpless and without influence."

Far too often power is determined or assumed by those who have possessions — good incomes or leadership positions, for instance — rather than by those with potential. Among the tools individuals can use to develop their own sense of competency, self-worth and inner power are the skills and willingness to give as well as receive, to share their time, talents and concerns for others.

d) "Virtue is worthiness judged by the values of one's culture, of family and friends. Without feelings of worthiness, life is not spiritually fulfilling."

One's feelings of being worthy or one's concepts of virtue can be forever affected if one grows up in a community in which the role models are greedy, materialistic, violent or poor. All children, regardless of ethnicity, gender, ability or cultural background, should have the right to develop a true sense of belonging to a loving, supportive family and community.

It may be that the tools necessary to create healthy self-esteem come from a journey back to traditions.

> ***"Success and mastery produce social recognition as well as inner satisfaction. Indian children were taught to generously acknowledge the achievement of others, but one person who received honor must always accept this without arrogance. Someone more skilled than oneself was seen as a model. The simple wisdom of the Indian culture was since all need to feel competent, all must be encouraged in their competency. Striving was for attainment of a personal goal, not being superior to one's opponent. Success became a possession of the many, not of the privileged few."***[10]
>
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Substance Abuse

The effects on child maltreatment

Drug and alcohol dependency is common among parents who maltreat their children. Studies suggest that substance abuse has been a predisposing factor in 50 percent to 95 percent of child maltreatment cases. There also is a high incidence of drug and alcohol abuse in adults who were sexually abused as children. The search to uncover how drugs and alcohol influence child maltreatment begins prenatally.

Each state sets its own laws that deal with prenatal drug use and abuse. In some states, such as Minnesota, a pregnant woman who ingests a "controlled substance" — specifically cocaine, heroin, phencyclidine, methamphetamine, amphetamine, or their derivatives — can be charged with child maltreatment.

It is estimated that every year up to 739,000 pregnant women use illegal substances.[1]

Infants who are prenatally exposed to drugs and alcohol may have a variety of difficulties. Some of these may be

Characteristics of chemical dependency

When one or more of the following characteristics is present, a person is said to be chemically dependent:

- **Physical addiction**
  When users try to reduce their intake or abstain from alcohol or other drugs, a physical addiction may be apparent.
- **Disregard of consequences**
  Although the person has been warned by a doctor, a partner or has lost a job, the person continues to use chemicals despite the consequences.
- **Compulsive behaviors**
  Psychological dependence on drugs and preoccupation with using drugs leads to compulsive behavior. Mood altering chemicals are used to escape unpleasant feelings or to decrease feelings of anxiety, pain and frustration.
- **Loss of control**
  Loss of behavioral and emotional control occurs with the ingestion of a determinate amount of any mood altering chemical.[2]

problems in learning, behavior, psychosocial skills and development. Some studies indicate that 65 percent of infants born to severely alcoholic mothers have fetal alcohol syndrome.[3]

A mother-child relationship is at a higher risk when it is compounded by social isolation, poverty, inadequate nutrition, limited intellectual abilities and inadequate prenatal care. These mothers may lead chaotic lives centered around the source of the next drug dose. The mother's thoughts are preoccupied with the drug, not with meeting the needs of the infant she carries inside her. It can be difficult, even for professionals, to sort out if the child is experiencing difficulty due to drug exposure or if it is due to the environmental risks described above.

Information from one school system that serves this population illustrates the following effects of prenatal drug exposure which may occur during pregnancy:

First trimester: From 13 to 56 days after conception, the fetus is at risk for structural damage or neurological impairment. Damage may include malformation of the eyes, kidneys, limbs, heart and lungs. Small strokes may occur in the brain.

Second trimester: Cocaine ingested into the blood stream of the mother may result in reduced blood and oxygen supplies to the placenta. The fetus may fail to develop properly, thus causing the baby to be undernourished and smaller than normal. The birth weight may be low and the baby may be shorter and have a smaller head. A full-term baby born smaller than normal actually may be at greater risk in development and learning capabilities than one born prematurely.

Third trimester: Cocaine ingestion causes contractions of the lining of the uterus and may cause premature labor and delivery. For many women who are addicted to drugs, this is further complicated by a lack of adequate prenatal care and by more infections than women who are not addicted. Drug ingestion by a pregnant woman can be a factor in premature delivery.[4]

No agreement has been reached on the issue of keeping a woman on methadone maintenance when she is pregnant. Some experts feel the risks to the fetus are too high; others say the alternative — the mother returning to heroin use — would pose greater risk to the fetus and to herself.

Statistics for some children prenatally exposed to crack and cocaine are grim:

- A newborn exposed to drugs is three times more likely to die in infancy than one who is not.
- Sudden Infant Death Syndrome (SIDS) is up to 20 times more likely in babies who are drug-affected. (The incidence of SIDS in the general population is one to two per 1,000; it has been reported as high as 170 per 1,000 in the drug-affected population.)

Facts on chemical use

Facts regarding drug and alcohol use in the United States:

- ✓ 15 percent of women of childbearing age (15 to 44 years) have problems with alcohol and other drugs.
- ✓ Approximately 11 percent of women have, during pregnancy, used at least one of these drugs: heroin, methadone, amphetamines, PCP, marijuana, and most commonly, cocaine.
- ✓ A very small percentage of female intravenous-drug users enter treatment programs. This population is not well-understood so it is difficult to design and implement education and prevention programs that will be effective.
- ✓ Up to 10,000 babies are born with Fetal Alcohol Syndrome each year.
- ✓ Fetal Alcohol Syndrome and Fetal Alcohol Effects in the United States cost nearly $340 million a year. They are among the leading known causes of mental retardation in the Western world.
- ✓ Alcoholism among American Indians has reached epidemic proportions and has been described as their No. 1 health problem. The incidence of Fetal Alcohol Syndrome is 33 times higher for American Indians than whites.[5]

- Failure-to-thrive syndrome may be far more frequent because of social and environmental factors and physical impairments of the infants.
- Intravenous drug use is a contributing factor in infants who contract HIV infections and AIDS.[6]

Children who have complications with prenatal exposure to drugs can be at higher risk for maltreatment because of their physical and neurological impairments. Simply put, it can be more challenging to properly care for and respond to these babies. Some of the manifestations of their impairments may be irregularity and inadequate feeding patterns, being overly sensitive or inadequately sensitive to touch, varying states of alertness, extremes in behavioral responses, difficulties around soothing and comforting, depressed movements and interactive behaviors, tremors, and difficulty in organizing behaviors.

The effects of alcohol on the growing fetus

According to many experts, there is no safe amount of alcohol during pregnancy. The extent of the damage depends on the amount consumed and at what point in the pregnancy it was consumed. When a pregnant woman drinks alcohol, she and her baby receive equal amounts. Alcohol goes directly to the placenta. Alcohol takes twice as long to leave the baby's body as it does to leave the mother's.

Fetal Alcohol Syndrome (FAS) is a medical diagnosis. Characteristics include growth deficiencies; physical abnormalities, especially of the ear, nose, and bridge between the nose and forehead; small head circumference; central nervous system disorders, manifested by developmental delays, difficulties in learning and memory, short attention spans and hyperactivity; seizures; and diminished intellectual

Characteristics of FAS/FAE

The Zero to Three National Center identifies characteristics for children with FAS/FAE at specific stages of development.

Infancy

usually small for height and weight; may show jitteriness, tremulousness, weak suck, hyperexcitability, and fitful sleeping; may have additional problems such as hypotonia (low muscle tone) and increased irritability; may have more difficulty "habituating" (getting used to stimulation in environment).

Preschool

often alert, talkative, and friendly; typically short and skinny, with butterfly-like movements; generally vigorous appearance; may have severe temper tantrums and difficulty making transition; can be hyperactive and over-sensitive to touch or other stimulation; can have attentional deficits, fine motor difficulties and developmental delays; otitis media, eye problems and congenital anomalies must be monitored; often rewarding but tiring to those around them.

Middle childhood

marked by hyperactivity, distractibility, impulsivity, and memory difficulties; usually affectionate and interested in those around them; often lack social skills to make friends or stay away from strangers; can have trouble making transitions and predicting consequences of behavior; developmental deficits may result in academic problems; tendency toward concrete thinking interferes with learning abstract concepts, especially math.

Adolescence and adulthood

characteristic facial features and growth deficiency of individuals with FAS/FAE are harder to recognize; usually remain short in stature and often have small head size; adolescent average IQ in the mildly mentally retarded range with a wide range of functioning from severe retardation to intelligence within normal limits; seem to "plateau" academically and in daily functioning, but problems grow more serious as attention deficits, poor judgment, and impulsivity create obstacles to employment and stable living; described as "innocent," immature, and easily victimized; at risk for serious life adjustment problems, including depression, alcohol abuse, and pregnancy.

Excerpted from Zero to Three/National Center for Clinical Infant Programs, Vol. 13, No. 1, pp. 42-29, Aug./Sept. 1992, "FAS and FAE; A Lifespan View, with Implications for Early Intervention."

capacity. FAS is the leading cause of mental retardation.

Fetal Alcohol Effects (FAE) is related to Fetal Alcohol Syndrome. The difference is that with FAE, there may be no apparent physical abnormalities, but neurological and central nervous system disorders can be detected. Behaviors run parallel to children diagnosed with FAS. It is not fully understood why some infants have FAS while others have FAE, though there is speculation that it is related to the amount of alcohol consumed and when during the pregnancy the drinking occurred.

Doctors estimate that Fetal Alcohol Effects may be three times more common than Fetal Alcohol Syndrome. Fetal Alcohol Syndrome occurs in one to three out of 1,000 live births, double the rate for Down Syndrome and five times the rate for spina bifida.[7]

The chance of maltreatment for children with FAS or FAE is heightened for two reasons: 1) the children are harder to properly care for because of their impairments; and 2) the mother may still be drinking.

Needs of families and children with FAE/FAS

Typically, families who care for a child with special needs require training and support. Many families would benefit from training in developmental psychology and from early intervention. In reality, however, the additional time required to respond to the child's special needs may not leave the parents with any time to seek out or utilize these resources. These families may also have a higher need for respite care because of the child's more challenging behaviors. Not just any babysitter or day care center will be able to respond appropriately to the child's special needs.

Individual programming is necessary to help families be the best that they can be. Individualized services that focus on the family's perceived needs will likely be the most effective.

The effects on attachment

Babies are born with behaviors that draw most mothers to interact with them. These include crying when needing to be fed, changed or comforted; using the mother as a base from which to explore the world, always knowing that mom is there to protect them; and smiling, cooing or responding to the mother's familiar voice and touch. Accurately interpreting the cues of infants, whether the cues are crying, facial expressions or body movements, allows parents to respond consistently to their needs.

Because of neurological damage, many babies who have been prenatally exposed to chemicals cannot read parents' cues and do not respond like a normal infant free of drug exposure. These babies may not be comforted by the mother's touch or voice. They may not have sufficient ability to snuggle and enlist attention. They may have insufficient eating patterns and may not be able to smile or maintain eye contact with the mother.

Likewise, the mother may not be able to read the baby's cues. She may experience high frustration when the baby does not respond to her efforts at soothing and caring. She may be consumed by acquiring more drugs, since the use of drugs during pregnancy is usually not temporary but rather part of a chronic addiction.

The mother may have feelings of guilt concerning her

drug use and may not be able to cope effectively with those feelings. When the mother has a very low self-esteem, she may feel anger and animosity toward the child. The care the mother provides may not be nurturing. All of these issues create additional risk factors for young children. Without intervention, the mother and baby are not likely to form the bonds necessary for healthy child development.

When prenatal exposure to drugs or alcohol is followed by inadequate infant care, babies may be placed in out-of-home care — usually with a relative or in foster homes. There may be risks in these environments, however, if the infants become overwhelming, the caregivers are undertrained, or the caregivers lack adequate support. This can result in numerous foster placements and a poor chance to attach to caregivers.

Substance abuse by parents and child maltreatment

To understand the relationship between parental substance abuse and child maltreatment, it is necessary to look at the behaviors exhibited by someone who ingests alcohol and/or mood-altering substances.

Characteristics of alcohol ingestion may include:

- maladaptive behaviors, especially assaultive and aggressive.
- central nervous system depression resulting in impaired motor skills and loss of coordination.
- emotional lability: flat affect or lack of response.
- decreased concentration.
- irritability.
- impaired judgment, both social and emotional.
- poor impulse control.

Withdrawal from excessive alcohol consumption produces an increased pulse and blood pressure; depression; anxiety; sweating; insomnia; headaches; weakness; nausea and vomiting; and, in severe cases, delirium tremors.

Characteristics of cocaine ingestion include:

- impaired behaviors.
- euphoria (cocaine is a central nervous system stimulant).
- grandiosity.
- impaired judgment.
- agitation.
- reduced inhibitions.
- increased sexual interest.

After a rush brought on by ingestion of cocaine, the following withdrawal symptoms may occur:

- headaches.
- palpitations and irregular heart rate.
- visual and tactile hallucinations.
- seizures.
- bizarre behavior.
- paranoid thoughts.

Discontinued use of the drug may produce anxiety, irritability, fatigue, insomnia, psychomotor agitation, further craving for the drug, and delirium.[8]

Once the effects of alcohol and other drugs are considered, it is easy to see why risk factors for child maltreatment are increased when a parent is a drug user. Recent studies consistently associate a high rate of physical abuse with alcoholism and a high rate of sexual abuse with cocaine ingestion.

The impact of one family member's chemical dependency is felt by all members in the family. Without intervention these physical, emotional and social effects can last a lifetime.

To restore healthy patterns in a family with a chemically dependent member, intervention needs to be aimed toward the entire family. There are three main themes apparent in these families: "Don't talk. Don't trust. Don't feel!"[9] To help families break the barriers created by these rules, the person who is chemically dependent, their significant other, and the children in the family must have permission to talk, trust and feel.

Aftercare is a critical issue for parents who have gone through chemical dependency treatment. People addicted to some drugs such as crack or cocaine appear to be particularly vulnerable to relapse, which puts their children at

repeated risk for abuse and neglect. Mothers of children whose disabilities resulted from the mother's addiction face the double challenge of: 1.) guilt for causing the child's disability, and 2.) the desire to escape the guilt and the additional responsibilities of caring for the child by resuming drug use.

Two factors that have a high correlation with successful recovery from alcohol and other drugs are: 1.) being employed; and 2.) the presence of a family that understands and supports recovery. Single, unemployed parents without a supportive, extended family may require more intensive aftercare programs in order to prevent relapse.

Professionals need to arm themselves with information about specific risk factors and their effects on families so they can support families that face living with the effects of chemical dependency.

Effects of chemical dependency

The effects of chemical dependency on children may include:

PHYSICAL: Fetal Alcohol Syndrome and Fetal Alcohol Effects and all the attendant problems caused by these conditions. There may also be inappropriate physical punishment and/or neglect of the children's physical needs, such as nutrition, hygiene, proper exercise and opportunity for supervised play.

EMOTIONAL: Insecurity; lack of trust; no sense of oneself as an individual; lack of personal initiative; behavioral problems; perfectionism; inflexible expectations of life; denial of painful feelings or perceptions; well-guarded defense mechanisms; excessive fears; inability to adequately judge dangerous situations; overwhelming desires to please others; and shame. (These symptoms are seen in children as they grow and develop.)

SOCIAL: Inadequate personal boundaries, sexual acting out, resistance to touch, blaming others, overwhelming need to be in control, rigid expectations of others, and compulsive or obsessive behavior patterns. (These behaviors are common in children as they grow older.)

The effects of chemical dependency on adults may include:

PHYSICAL: Great tendency for illness and psychosomatic complaints; behaviors that set oneself up to fail; increased physical and mental health problems.

EMOTIONAL: Decreased self-esteem; frequent crises; shame; inability to trust; a sense of autonomy; rigidity in behaviors, beliefs and attitudes about oneself and others; well defended denial system; perfectionistic beliefs; increased mental health issues; and in some cases Post-Traumatic Stress Syndrome.

SOCIAL: A need to take care of others; sexual dysfunction; rigidity around behaviors and attitudes toward self and other; shaming toward others; overcompensation for feelings of inadequacy by controlling others; projecting blame onto others; unable to sustain relationships with peer group; extreme sense of responsibility or irresponsibility; inadequate personal boundaries; and assumption of the role of a martyr.

The effects of chemical dependency on the family may include:

PHYSICAL: Severe stress brought on by continual crisis, money problems, emotional and verbal conflict, marital discord, and possible physical abuse.

EMOTIONAL: Creation of a fantasy family image to replace the real family, unclear roles of family members, parent-child reversal of roles, no interconnection of family members, and abusive and shame-based family systems.

SOCIAL: Inflexible and controlling behaviors and attitudes surrounding the family, individuals and the world; abusive family systems (including emotional abuse and neglect); chaotic lifestyles; failure to follow through with plans; lack of consistency to family members and peers; and perfectionism

(Adapted from Process Parenting, 1988.)

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Domestic Abuse

The effect on children

"Your abuse is the ring in my ear,
Your blows are my toe-rings,
If you kick me, it is my pulse and my rice,
The more you beat me with your shoes,
The more we are united."

Muria Gond-India's poem captures the complicated, seemingly contradictory emotions experienced by a battered woman. Victims of battering are often caught in a cycle of abuse and love. In order to feel loved, the woman may accept the battering or even become dependent on it because she believes she deserves it.[1]

Illustration by Toni Parrish

There are stories in the media nearly every day about women who are abused or killed by current or former partners. The questions society asks often raise doubts about the victim rather than criticize the perpetrator: "Why would anyone stay with him if that were going on?" "What did she do to cause her partner to react in that manner?" "The way she nags all the time, is she asking to be hit?"

There is an array of justifications and rationalizations for battering. Most of these revert to viewing a woman as a man's possession, which gives him the right to "keep her in line" however he sees fit. Men rarely pronounce these justifications; more often they are unstated but firm beliefs. Examples of reasons why some men think a woman "deserves" to be beaten are: a) she does not live up to the image society has created for a wife; b) she cheats on her husband; c) the children misbehave and it is her responsibility to make sure that doesn't happen.

It has been estimated that nearly one-third of married women have experienced violence in their relationships.[2] To put the issue into perspective, in six of the Vietnam War

years (1967-1973), 39,000 U.S. soldiers lost their lives. During the same time span, 17,500 American women and children were killed by members of their families.[3]

Men who batter share these characteristics:

- may lack verbal skills necessary to handle a concern or problem nonviolently
- demonstrate poor impulse control
- rigid and demanding in controlling their behaviors and that of family members
- have trouble interpreting behaviors of partner
- promote family isolation and secrecy
- extremely jealous
- create a sense of fear in family members
- use or abuse alcohol
- minimize violent behavior[4]

Authors of Children of Battered Women note: "The Battered Woman's Syndrome is marked by a victim's increasing sense of helplessness and hopelessness about finding safety and terminating the violence. The feelings are reinforced by a sense of isolation and poor self esteem, fostered by the batterer. Over time, victims begin to deny and minimize the extent of violence and underestimate the lethality of the situation for themselves and for their children."[5]

Women may stay in relationships well into the battering cycle for a variety of reasons. The battered woman loses her sense of self worth apart from the relationship with the batterer. She often believes there is no way she can manage outside of the relationship, a message the batterer repeatedly communicates in order to foster dependency. She fears economic hardships, losing her children and retaliation from him if she tries to leave. She typically does not know where to go for help, believes she was partially — if not fully — responsible for the abuse, and thinks this only happens in her household.

When a woman is pregnant, battery and violence can cause a child to be born with a disability. In fact, studies indicate that in battering relationships, violence may be more frequent and more intense during pregnancy. There are several reasons for this:

1. Transitional stress created by the pregnancy.
2. Sexual frustration.
3. Response to behavior resulting from pregnancy: for example, a woman might be nauseated and unable to cook; she may need to take frequent naps and, as a result, not be able to finish the housework.
4. A conscious or unconscious desire to hurt the fetus.
5. Decreased capacity of the mother to defend herself.[6]

It is unfortunate, but true, that many professionals still do not understand that women are not at fault for being battered. When the victims can feel safe and receive the kind of support they need, they can begin to look at the complex nature of battering.

Domestic violence hurts a woman physically and emotionally and also may temporarily reduce her ability to appropriately parent her children. A woman who has been battered has a strong desire to protect her children — both from becoming victims and from witnessing the ordeal. This instinct to protect can be so overpowering. The woman cannot move beyond it and is emotionally unavailable to her children in other ways.

Women who have been battered need to deal with their own trauma before they can respond appropriately to their children's needs. It is akin to the emergency instructions on airplanes that advise parents to put the oxygen mask on themselves first, then on their children. A battered woman who does not attend to her own needs might try to minimize what happened to her. She may want to deny the violence and may become irritated when the children ask her questions. She might seek support from her children and become upset when they cannot meet her needs. Some mothers who are victims of battering remain detached from their children throughout their developmental years. The impact from this can be as profound as if the children personally experienced violence.

A look at power and control

Battering produces an imbalance of power and control in relationships. Th diagram illustrates what constitutes domestic abuse. Not all the actions are physical, and bruises are not the only tell-tale marks of an abusive relationship.

Violence
Physical
Sexual
Using coercion and threats
Making and/or carrying out threats to do something to hurt her • threatening to leave her, to commit suicide, to report her to welfare • making her drop charges • making her do illegal things.
Using intimidation
Making her afraid by using looks, actions, gestures • smashing things • destroying her property • abusing pets • displaying weapons.
Using economic abuse
Preventing her from getting or keeping a job • making her ask for money • giving her an allowance • taking her money • not letting her know about or have access to family income.
Using emotional abuse
Putting her down • making her feel bad about herself • calling her names • making her think she's crazy • playing mind games • humiliating her • making her feel guilty.
POWER AND CONTROL
Using male privilege
Treating her like a servant • making all the big decisions • acting like the "master of the castle" • being the one to define men's and women's roles.
Using isolation
Controlling what she does, who she sees and talks to, what she reads, where she goes • limiting her outside involvement • using jealousy to justify actions.
Using children
Making her feel guilty about the children • using the children to relay messages • using visitation to harass her • threatening to take the children.
Minimizing, denying and blaming
Making light of the abuse and not taking her concerns about it seriously • saying the abuse didn't happen • shifting responsibility for abusive behavior • saying she caused it.
Physical
Sexual
Violence

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Children in these violent environments are affected, even when they are not the immediate target of the violence. Many battered women witnessed violence by their father on their mother. How children who witness violent domestic attacks respond depends on their stage of development, gender, and role or place in the family.[7]

The effect of parental battering on infants is largely determined by whether or not there was a disruption in feeding, sleeping and nurturing. When the mother is under high stress, she may not be "emotionally available" to the baby, which can have long term damaging results as the baby grows and develops.

The effects on older children who tend to act out their feelings may be more evident. Many demonstrate various emotional and behavioral problems and have difficulty with power and control issues. Girls may demonstrate learned helplessness and boys may re-enact the dynamic in their home with playmates. This aggressive behavior may cause problems in school that, in turn, creates additional stress in the home.

The stress children feel at home can cause excessive fears and anxieties that interfere with their ability to learn. Children often identify with the person who has power. Their father might use the children as another weapon against the mother.

Children who come from homes with spousal abuse frequently believe they caused the conflict. As a result, they can be overwhelmed by feelings of guilt and shame. They may experience withdrawal, sadness, conduct disorders, regression in toileting habits, defiance, clinginess, psychosomatic complaints, sleep disorders, cruelty to animals, and destructiveness. Notably, many of these behavioral responses are similar to children who have been abused themselves.

Illustration by Toni Parrish

Help for children from battering relationships

Children who enter battered women's shelter programs are encouraged to discuss their feelings. Advocates use a variety of methods to help children understand what they have been through. Techniques that incorporate play, such as drawing, clay sculpture and painting, help children better express themselves. The children's behaviors, which developed over time, may have become internalized. They may represent how they see themselves, their families and the world. The behaviors are survival skills that have allowed them to function in violent homes. Much time and energy may be required to change these behaviors and help children learn healthier ways of interaction.

One critical issue for boys who have witnessed violence in their homes is that most child advocates in shelters are women. While they can influence and help children look at a situation differently, boys also need positive male role models. Otherwise, they may retain misconceptions about what is and is not appropriate male behavior.

Child advocates need to recognize the delicate nature of the "secret" that children feel compelled to keep. For many children, the ability to trust has been shattered. Child advocates spend time with the children and allow them to become comfortable before they expect them to reveal valuable family information.

Children who witness domestic abuse will benefit from learning to recognize and understand their feelings. They may need a safety plan, the ability to identify the people in their lives who they can go to for support, how to deal with anger in different ways, and permission to acknowledge that they wish their families could be different. They may need to know why the violence occurred and that they are not to blame. These children will likely require opportunities to practice the new skills before they can internalize those skills.

Professionals in a program for young boys who had witnessed violence used role play to assist the boys in demonstrating and understanding their feelings. The boys pretended they were on television and made commercials about themselves. Sometimes they would tell stories about their families and create new endings, patterned after what they were learning about themselves in group. When the boys would become too loud, they were asked to turn down the volume. The TV concept was not used as a time out but rather as a creative way to help the boys learn about their feelings and self control.

Children who have witnessed or been victims of violence may continually scan their environment for safety. This watchfulness can prevent them from participating in everyday activities. When this occurs, it is helpful to assist the child in finding a safe place. For some children, it may be under their beds or on the couch curled up in their favorite blanket; for others, it may be in the school nurse's office or library. They can be given permission to go to their safe places when they feel scared or threatened. Children benefit when adults respect their need for privacy. Adults working with the children should check on them frequently and ask how they are doing. They should never push the child to leave before he or she feels safe and ready. If children have chosen their bedrooms or closets, the doors need to be open so adults can supervise but not invade the safe place.

Affects of battering relationships

Connie's Story

The childhood sexual abuse by her father made Connie a very vulnerable teenager.

She became extremely angry and aggressive when provoked, or else she denied her feelings and became isolated and depressed.

When Connie was 16, she met Ken, a charismatic man in his 20s who promised her a better life. Although Ken persistently used drugs, displayed a violent temper and psychologically controlled Connie, she felt comfortable with him. It was the familiar dynamics of her family, just different players. If Connie said something happened on Tuesday, Ken would say it happened on Wednesday and would verbally badger her until she agreed.

After six months they married because Connie was pregnant. She thought this would help change things. Now she would have the baby: someone to love who would not take advantage of her or manipulate her love.

Connie began to feel increasingly lost and isolated, but Ken convinced her it was just hormonal. The pregnancy was a threat to Ken, who increased his use of drugs. When Connie complained of being tired or uncomfortable, Ken flew into a rage, belittled her, called her names, hit her, and then justified his action by telling her what a selfish person she was: she thought only of herself, not him and his needs.

One afternoon their fight was worse than the others. Ken stormed off to a bar down the street. Exhausted and relieved that he was gone, Connie fell asleep on the sofa. She awoke to him slapping her and demanding his dinner. Connie jumped to her feet and ran to the kitchen to prepare a meal. As she was putting the final touches on dinner, Ken took a look and began to rant, "This isn't fit for a dog! You can't do anything right since you got pregnant!" He kicked the dishes out of Connie's hands. "I'll solve this," he hissed.

Ken doubled up his fist, then punched Connie in the stomach — three times with all his might. He left yelling that when he returned, there had better be something "decent" on the table.

Connie lay on the floor writhing in pain. She managed to work her way to the phone and call 911.

She lost her baby and nearly lost her life. Connie could deny the injuries to herself, but the loss of her baby was all too real.

It is a tragic truth that stories like Connie's are everyday occurrences.

Battery to the fetus appears to be more dangerous than other forms of trauma or abuse.[8] The babies who survive such traumatic episodes are two to four times more likely to be born with low birth rates.[9] While low birth weights do not automatically mean the baby will have a disability, women who are battered during pregnancy are twice as likely to have complications than women who are in a car accident or sustain a fall.[10] Some data suggests that battered women are four times more likely to have a child born with a disability.[11]

Sarah's story

Sarah, a tiny lady, came to a women's shelter in a rural community. Amy, her 10-month-old daughter, and Brian, her emotionally disturbed 9-year-old son who was as tall as his mother, were with her.

Sarah's history included being battered as a child by her mother and father. Her second husband (Amy's father) beat her, as did her first husband (Brian's father).

Staff members at the women's shelter observed multiple contusions and large patches of missing hair on Sarah's head. The baby, Amy, was difficult to comfort and cried continuously. Brian was aggressive and harmed other children in the shelter, but would not take responsibility for his actions.

One day Brian placed a pillow over Amy's head in an attempt to quiet her. The staff intervened, and then Brian went after his mother, grabbed her hair, kicked her feet out from under her and dragged her, screaming, "It's all your fault I'm doing this; you made me mad on purpose."

Two days later the staff took Amy for a medical examination because her crying did not stop. The physician discovered the infant had a tear in her vagina and scarring around her cervix. There was conclusive evidence that the infant had been sexually abused. Sarah, however, was not able to give the authorities any information.

Sarah's story sadly, but clearly, illustrates the multi-generational effects of abuse. Sarah was abused by her parents and both husbands. Brian, victimized by witnessing the abuse by his father and stepfather, imitated their behavior and physically abused his mother, then his half-sister. Amy was sexually abused by some adult man (it was not determined who) and was neglected by her mother, who was unable to protect her.

Commentary

The above anecdotes are depressing, yet very real. Children who are abused lack the skills to be parents themselves unless there is appropriate intervention when they are adults. Their interactions with their children will align closely to their own unfulfilled needs. They may be well-intentioned but emotionally incapable of understanding the baby's needs. And so the cycle of abuse continues.

Children with disabilities are even higher-at-risk for maltreatment when their parents were abused as children and there has been no intervention. Greater maturity is required to raise a child with a disability because more time, understanding and patience are necessary.

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Community Violence

The effect on child development

The United States ranks fifth in the world in the number of murders annually.[1] Violence is witnessed by young children in their homes, schools, streets and in the omnipresent media. On average, children entering the first grade have spent one-third of their waking hours watching television. The average elementary school-aged child sees 18,000 murders and more than 100,000 other violent acts on television.[2] The effect of this violence on young minds is the focus of much research and debate.

Children learn to trust during the first three years of life. When they are raised amid violence, the results can be lifelong and tragic. Outcomes are thought to be better when families are able to meet children's basic needs through nurturing, being consistent and having adequate support. This is rare in community housing projects and other neighborhoods where violence and danger are chronic. The negative effects are heightened when domestic violence is also a part of the child's home life.

Violence creates a clash between what the parent is capable of providing and what the children need. This is particularly the case with very

What we know

These statistics illustrate the effects of violence on children:

- ✓ **3.3 million children witness parental abuse every year.[3]**
- ✓ **Physical abuse is the leading cause of death among children under age 1.[4]**
- ✓ **Homicide accounts for 10 percent of all deaths of children ages 1 to 4.[5]**
- ✓ **90 percent of children who died as a result of neglect were under the age of 5, and 53% were under the age of 1.[6]**

Other effects of violence on children

- Children model their behavior after those who have power and control. Unfortunately, these are often the people who initiate violence. There is an increased chance that children exposed to such role models will become violent.
- Children who do not have positive role models may not be able to visualize themselves in meaningful roles.
- The very people who are there to protect the children and families — the police — also are seen as dangerous. Children may become confused about who the "bad" guy is. They may know who the drug dealer is in their neighborhood and he may be a relative or friend who gives the family money and food, whereas police may be viewed as "enemies."
- Children who are constantly scanning their environment for danger are not in the emotional posture necessary for learning.
- Many children may believe they are responsible for the violence.
- Children are unable to determine what is real and what is not.
- Children feel powerless and helpless.[7]

young children, where exposure to violence can interfere with children developing secure attachments.

Many children live with the realization that their parents cannot keep them safe. Some children seem to suffer while others fare much better. A child's inner resiliency is a critical factor in predicting his or her ability to cope with violence and chronic danger. Characteristics that determine how children succeed under stress include:

- age of child.
- neighborhood in which the child lives.
- amount of consistent care and structure in the life of the child.
- caregiver's support.
- how much violence (including abuse) the child has been exposed to previously.
- proximity of child to the traumatic event.
- child's relationship to perpetrator and victim.[8]

Preschool children are at risk to be most traumatized by violence occurring around them.

Many children who have grown up in "urban war zones" do not come through the battle unscathed. They may need extensive treatment to change behaviors that served them well in their early childhood. Recurring themes are feelings of extreme vulnerability and fear of death. Children may feel excessive anger because adults failed to adequately protect them.

Childcare providers who work with children from birth through 5 express frustration at not knowing how to respond to the stories of violence and fear expressed by children. Play is an essential tool to help reverse the fears of children raised in violent communities. Play allows children to view their world from a more neutral or secure place. Play helps children:

- develop a sense of direction.
- experience a variety of activities.
- increase their ability to interact with other children and adults.
- develop a sense of humor that can serve as a survival tool.
- learn flexibility.
- take risks without a sense of failure.
- relax and escape stressful events when necessary.
- express their thoughts.
- create their own endings for their experiences and thus learn how to bounce back from life's stressful events.

Children who have adequate play skills learn how to appropriately channel their aggression. Children who have not developed adequate play skills tend to act out in ways hurtful to others.

Professionals should try to explain to parents the negative effects of physical punishment and describe alternative mechanisms for discipline. This is particularly important for parents who themselves

were physically punished as children and who don't know other methods of discipline.[9]

Childcare workers who live in safe neighborhoods can be overwhelmed by stories the children relate of violent acts they have witnessed. Before these workers can adequately respond to the children's needs, they must have the opportunity to discuss their own feelings of how to respond and receive support.

Lorraine Wallach has identified four mechanisms for childcare providers to help children survive in dangerous neighborhoods.[10] Wallach believes that individuals who come in contact with these children can make a significant difference in their lives. The four mechanisms are:

1. Childcare providers need to ensure that their programs provide opportunities for children to establish meaningful relationships with adults who genuinely care and are knowledgeable of the needs of the children.
2. Childcare providers need to provide consistency whenever possible.
3. Childcare providers need clear expectations and limits for the children based on the children's functioning capacity.
4. Workers will be the most successful when they provide unconditional support to the children while giving them opportunities to practice what they learn and to express themselves.

Helpful hints for parents

The Zero to Three/National Center for Clinical Infant Programs in Arlington, VA[11], provides a number of helpful hints that can be given to parents so they can help their children appropriately channel their aggressive energies. Parents are more successful when they try to:

- **Remember that when children feel loved and cared for, they are more apt to accept the guidance parents provide.**
- **Discover what triggers aggression in their children.**
- **Use what they know about their child's temperament, rhythms, preferences and sensitivities.**
- **Tell their children what they want them to do in specific situations. It is very important, however, that the parents do not lecture.**
- **Watch their children when they play with others. Allow them to work through conflicts when they are able.**
- **Identify where children are aggressive in ways the parents don't like, and then direct their attention to something else. Parents should try to teach children how to use aggression in a healthy way.**
- **Demonstrate to children how to handle conflict.**
- **Help children who have language skills explain their emotions.**
- **Ask themselves if they are sending "mixed messages" about aggression to their children.**

Sometimes adults say "Well, children are too young to remember, so this incident will not hurt them." This myth is directly responsible for too many young children not receiving the intervention or treatment that could prevent recurring problems as they grow older. Increasingly the evidence suggests that children, even infants, have the capacity to remember incidents of violence.

The National Center for Clinical Infant Programs[12] identified other reasons why parents may not adequately respond when their children have been exposed to violence:

- Parents, due to their own exposure to violence, are too preoccupied to see their children's issues.
- Parents want to forget painful experiences; they believe it will upset children too much to talk about their experiences.
- Parents normalize the reactions of children who witness violence as natural.

The effects on children who witness violence

There is a considerable body of literature on children who are victims of abuse or violence. Relatively little attention has been paid, however, to the effects of children repeatedly witnessing violence where they were not a direct victim.

Here are some facts:

- The rate of wife beating is 1,000 percent higher for men who witnessed family violence in their childhood than for those who did not witness violence.[13]
- Boys who had been exposed to family violence/wife assault had a level of emotional and behavioral problems that resembled boys who had themselves been physically abused.[14]
- Among boys and girls exposed to violence, it was found that boys demonstrated negative effects both inward and outward in social skill development, while girls turned the effects more inward. Boys had a greater difficulty forming peer relationships and performed much lower in achievement tests. Boys were observed fighting and destroying property while girls demonstrated withdrawal and anxiety.[15]
- Children exposed to family violence have inappropriate views on the acceptability of violence as a means of conflict resolution.[16]
- Children are more likely to imitate violence if they strongly side with the perpetrator and if the violence is successful in gaining power and control.[17]
- Approximately 60 percent of boys who were termed "bullies" in the 6th and 9th grades had at least one conviction by age 24, while 35 to 40 percent had three or more convictions.[18]

The numbers are staggering and the stories horrifying. Society's neglect of children

Illustration by Toni Parrish

and families with multiple risk factors paints a very bleak picture. How families interpret what is going on around them directly relates to how families function. Hope — necessary for individual growth and healthy functioning — is absent for so many.

If the cycle of violence is to be broken, there must be early intervention with young children. There is strong evidence to support the need to teach alternatives to violence in our homes and schools.

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Parent-to-Parent Models

The value of support programs

Many parents who have children with disabilities and who also are at risk for child maltreatment benefit from discussions with other parents in similar circumstances. Professionals can provide information on keeping families strong, but parents also benefit from sharing experiences with other parents who have traveled similar roads.

Parents can trade information on community resources — which ones were helpful and which were not; where to go for financial help; and what to do at 4 a.m. when no one else is there. This practical information can be critical to the family's functioning. Talking about experiences with other parents can be empowering and reduce feelings of isolation. A supremely frustrating event can provoke humor and determination when shared with another person who has had a similar experience.

The Individualized Family Service Plan

The Individuals with Disabilities Education Act (IDEA)[1] paves the way for community-centered care for children ages birth to 5. Part H of IDEA specifies services for children ages 0 to 2; Part B of IDEA specifies services for children ages 3 to 5. Each requires children with a disability to have an Individualized Family Service Plan (IFSP).

Elements of an IFSP

1. Multidisciplinary assessment and identification of appropriate services.
2. A written IFSP by a multidisciplinary team and with parent or guardian.
3. Early intervention services, with consideration of frequency, intensity, and method of delivery.
4. Expected outcomes for child and family.
5. Projected dates for services.
6. Service coordinator named from the most relevant profession for the child's needs.
7. Transition to Part B services (special education, related services starting at age 3).

An IFSP defines services to be provided to children with special needs and their families. A multidisciplinary team, which includes parents, develops the written IFSP. The IFSP must be reviewed annually.

The IFSP is centered on the entire family's needs rather than only the needs of the child with a disability. The IFSP should include information about the child's present functioning in the area of physical development, language and speech development, cognitive development, psychosocial development, and self-help skills. The IFSP should also include the family's strengths and needs related to helping the child's development.

What does this new law mean for early childhood professionals?

If you are an early childhood special education teacher, you may be asked:

- to provide service coordination for a family who has a young child in need of special services.

If you are a child-care provider in a preschool or daycare setting, you may be asked:

- to provide services that give the family a respite, or break. That may allow them to have social interactions with others or simply to rest and have time to care for themselves.

If you are a teacher in a Head Start program, you may be asked:

- to observe the child's development and participate in assessment and referral to other programs for further needs.

In all of the above roles, you may be a team member participating in the preparation and implementation of an IFSP or an Individualized Education Plan (IEP) for a child with special needs. An IEP is an educational plan implemented in the public school system beginning in kindergarten.

Part H of IDEA is different from previous legislation in that it has a threefold approach: 1) a strong emphasis on families; 2) the development of comprehensive, community-based systems; and 3) interagency cooperation.

States will be required to provide prevention and early intervention services for children with disabilities and their families. This should improve access to resources, particularly for low-income families.

The benefits of parent-to-parent support

One foster mother called a parent center to ask for resources for a child who had lived in her home for two months. The foster mother was obviously upset and needed someone who could really listen. After the woman explained her situation, the parent advocate asked, "Do you really want to be a foster parent for this child?" The foster mother broke down and told the advocate that she had taken in many children and that she had been able to provide a nurturing environment that allowed them to grow and blossom. However, this particular child could "push all of her buttons." In a low and tearful voice she stated that no, she did not believe she could really help this child. The two mothers discussed options and the foster mother's fears that the social service system would not place more children in her home if she removed this child from her care. Once the foster mother was able to truly express her concern, she then was able to carry through with a plan that would benefit the child and herself.

Parents can express to other parents their heartfelt feelings about their vulnerabilities, explore options that may be painful to consider, and develop plans that will be the best for all concerned. The foster mother probably would not have told a professional that she did not want to care for this child. Instead she may have continued to struggle until a crisis erupted, which would have led to removal but with much different dynamics and with a much greater toll on both the foster parent and child.

Many organizations can focus only on a single concern even though the family has multiple needs. This means the family must seek help from a variety of agencies, each of which addresses only a slice of the overall, complex problem.

Even when families have made progress, they may feel overwhelmed by the need to respond to the variety of agencies they are referred to for an array of specific issues. These families could use assistance in juggling the various resources. The lack of such assistance can discourage the family from seeking out additional services that may be potentially beneficial.

One model of parent-to-parent support groups, Parents Anonymous, has played a monumental role in facilitating the benefits of parents reaching out to other parents in times of need. Parent groups staffed by professional volunteers or seasoned parents have sprung up quickly around the country.

There are a number of other programs nationwide that utilize the parent-to-parent support model. The following programs are examples of efforts that may help parents stengthen their relationships with their children. Addresses are provided at the end of this chapter so that readers who want additional information can contact the organization.

Appeal of support programs for parents of children with disabilities

What makes a parent-to-parent model so appealing for parents of children with disabilities who are at risk for maltreatment?

- **It offers a sense of community where formal and informal support is provided. It allows parents to be heard and is a mechanism for sharing tears as well as joys. It creates a safe environment where parents can freely discuss their feelings without censorship.**
- **It reduces isolation and can serve as a respite time.**
- **It allows parents who have successfully responded to the trials they faced to serve as models. This helps other parents who have relationship difficulties with their children envision positive changes in their families.**
- **It allows families to be exposed to perspectives different from their own and gives parents new ideas for interactions with their children.**
- **It offers support at times and locations convenient to the parent and allows follow-up phone calls whenever parents most need support.**
- **It offers parents a network to learn of sensitive agencies and workers and teaches parents how to access "the system." It promotes advocacy for all families by creating a unified voice to influence policy.**
- **It allows families to receive culturally specific information and to network with people of the same ethnicity.**

Massachusetts Parenting Partners

The State of Massachusetts has created a program to keep children in their homes using existing resources.

The program uses social service staff who train foster parents to be parent aides. Once the foster parents have completed the training, they are matched with families who need assistance, knowledge and support in meeting the needs of their children. They observe relationships in the families' environments and then help families learn new parenting techniques and coping skills. They also provide information about community resources, provide child care, assist in transportation and offer one-to-one support to parents.

Parent aides can address such issues as abuse and neglect, depression, illness, chemical dependency, isolation, joblessness and homelessness. They work with families for up to 14 hours per week, and also can provide up to three nights of respite care per week. They are paid in accordance with what they would receive if the children were in their homes.

There are many benefits in this program: there is little start-up cost; existing staff is used; and fewer children need to be placed out of their homes. The cost per child is half what it would be to place the child out of the home, and the emotional cost to the child is greatly reduced.[2]

Family Resource Centers

The development of family resource centers is widespread in a variety of communities. On-site assistance is dependent on services and resources from the community. Many centers focus on working with children in the context of families and the community. They provide services by emphasizing family strengths and offer a broad range of services to families who may have multiple needs. They encourage parents to expand their coping skills. They help parents develop practical information, especially on child development and how to be a proactive parent who strives to intervene before a crisis occurs. They encourage respect for a variety of cultures and provide recreational activities for adults and children. They provide services locally and link families with similar issues and concerns.

Family resource centers are locally based, which decreases transportation barriers, and they are open a variety of hours to better serve the time demands of families. Staff members often live nearby, which helps strengthen the program by creating community ownership of the centers.

Friends of the Family, Baltimore, MD

In 1986 a handful of family service personnel formed a partnership with the ambitious goal of saving Maryland's children. Friends of the Family is based on the realization that as family problems increase, so do social problems. The solution was to develop a family support system to help raise healthy children and build productive futures.

The family support centers are located in neighborhoods with high rates of poverty, adolescent pregnancy, low birth-weight babies, high school dropouts, child abuse and neglect, unemployment, and children who are not adequately prepared to enter school. Centers provide comprehensive, preventive services on a voluntary basis. The services include parenting education, child care for infants and toddlers up to 3 years old while their parents are on site, health education and referral, education and job services, recreation for parents and children, service coordination with other agencies, developmental assessments of children and remediation of developmental problems either on site or by referral, advocacy and community building, short-term counseling, adolescent pregnancy prevention programs, and in-home visitation for hard-to-reach families.

Family centers empower neighborhoods and families. Participants are treated as equal partners, not as "clients" or "cases." Participants share in policy decisions and program development.

The program reported these accomplishments in 1992:

- Fourteen family support centers provided service to 4,185 parents, young children and nonparenting participants.
- Ninety-three percent of participating children aged birth to 5 have up-to-date immunizations, compared with 56% statewide.
- Eighty-three percent of the teen parents who were not high school graduates are enrolled in school or working toward a GED.
- No child in any family participating at a family support center was removed from the home.
- Forty-eight percent of children in foster care were returned to their families.
- Of the estimated 361 parents under the age of 19 who came to the centers, only 24 had repeat pregnancies.[3]

Resource Mothers

Mentoring models using trained volunteers to help other parents have become more popular. One model is Virginia's Resource Mothers Program, which is community-based and designed to assist teen mothers. This is a collaboration among the Virginia Task Force on Infant Mortality, Virginia Department of Health and Human Services, Norfolk State University, Public Health, and the City of Norfolk.

Resource Mothers are experienced parents or paraprofessionals specifically trained to help pregnant teens and teen parents. The program's goals include fostering healthy pregnancies, enhancing the mother-child

bond, and supporting the mothers and babies through the first year of their lives together. Resource mothers are provided with continual supervision, support and additional education.

Home Visitation models

Home visitation models have increased in the past few years. Their popularity may be due to the fact that they allow programs to reach parents and families that traditional site-based agencies have missed.

Many models of home visitation exist. Some use public health nurses, while others train community members to help decrease isolation for parents who need assistance. Some home visitor programs have funding that can meet immediate needs of families: the amounts differ as do the policies governing how the money can be used. A large prevention program using a home visitation model is Hawaii's Healthy Start Program. This program is voluntary for all new parents.

There are nine features of the Healthy Start approach:

1. Systematic hospital-based screening identifies 90 percent of high-risk families of newborns from a geographic area. A paraprofessional "early identification" worker analyzes records of eligible mothers in a certain area, using a list of indicators developed by the Hawaii Family Stress Center. Families determined to be high-risk are offered home-visitation services.
2. Community-based, home-visiting family support centers are part of the national Maternal and Child Health system. Initial visits are devoted to building trust with the parent, assessing needs, and helping with immediate needs.
3. The intensity and array of services are individually based on the family's needs and level of risk.
4. There is linkage to a "medical home" to promote preventive health care which is an important aspect of positive child development.
5. Health and social services for at-risk families are coordinated. High-risk families often do not trust professionals and, as a result, avoid reaching out for help. This can result in a situation where those families who need services most are least likely to seek help.
6. There is continuous follow-up with the family until the child reaches age 5.
7. There is a structured training program in the dynamics of abuse and neglect, early identification of families at risk, and home visitation.
8. There is collaboration with the Hawaii Coordinating Council, which provides funding to serve "environmentally at risk" children.
9. Staff selection is specialized, and there is long-term retention of staff members.

Currently in the United States, a universal Healthy Families America program is being developed. The effort will be a voluntary, home visitation program for all new parents. This model will enhance home visitation programs that already exist in various areas.[4]

Success with home visitation programs

Using data from the Hawaii program, the National Committee to Prevent Child Abuse identified the best practices to ensure success of the program. They are:

1. All replication efforts should begin with a comprehensive needs assessment to identify the size of the target population, the capacity of the current services to address the needs of the population and the relevant actors/advocates needed to create a fully operational and funded Healthy Families America (HFA) initiative.
2. While the primarily goal of the HFA initiative is to cover the entire state, this goal may be best served by establishing one or more pilot projects targeting a specific geographic area.
3. To the extent possible, replication efforts should use existing home visiting services and other support programs for new parents.
4. Services need to be initiated at the time a child is born, or earlier if possible.
5. Ideally, all new parents will be offered some services, with intensive service offered to high-risk parents.
6. A standardized risk assessment protocol will be used to systematically identify those individuals at highest risk for maltreatment.
7. Services will be offered to high-risk parents in a positive but voluntary manner.
8. High-risk families will be offered home visits. These core services can be supplemented with a variety of other center-based services.
9. Services will be intensive. High-risk families will be seen at least weekly for as long as is necessary.
10. Services will be long-term. Programs will have the capacity to serve high-risk families for up to five years or until the child is enrolled in Head Start or a similar program.
11. Services will address a range of risk factors including knowledge of child development, discipline skills, health care, use of other support services, and economic and emotional stability.
12. While all high-risk families will receive a core body of knowledge or assistance, the materials or services will be tailored to a family's particular needs and characteristics.
13. In hiring home visitors, emphasis will be placed on selecting individuals capable of developing trusting, nonjudgmental and supportive relationships with families.
14. All workers will be required to complete an intensive initial training program and periodic in-service training.
15. Ongoing, professional supervision of all home visitors will be maintained to ensure program quality.
16. Because of the intensity of service, case loads need to be limited. No worker, for example, should be working with more than 15 of the highest-risk families at one time.

When these guidelines are incorporated and measured, substantial impact on child maltreatment rates can be achieved.[5]

Steps Toward Effective, Enjoyable Parenting

STEEP is located in Minneapolis, Minnesota. This prevention program seeks to promote healthy parent-infant interaction and reduce abuse and neglect of children born to at-risk mothers. Women are referred to the program through obstetric clinics during the second trimester of pregnancy. Those identified as at-risk include women with low incomes and high school diplomas or less. Participation is voluntary. The STEEP program combines weekly home visits and weekly parent-infant groups that promote parental understanding of child development and behavior, sensitivity to the baby's cues, strengthening of social support networks, insight into how one's own experiences influence parenting, and general coping and life-management skills.

Home visits focus on helping mothers build their strengths, helping them identify community resources, and linking them with appropriate services. The program serves first-time mothers who

are 17 or older. It provides services during pregnancy and following birth until the child's second birthday.

The population this project serves is 55 percent Caucasian, 40 percent African-American, and 5 percent American Indian. The average age of mothers in the program is 20 years old. The average completed grade level is 11th grade. More than 90% of the participants are single. This population has a high mobility rate. Eighty percent of the mothers were physically or sexually abused as children. Eight percent are in abusive relationships with a spouse or partner. Ninety percent are low-income or AFDC recipients with a maximum of a high school education.

In preliminary findings of an 18-month study of 75 mothers and their children, there was a 10 percent dropout rate. Compared with a control group, mothers in the program better understood their children, were more organized, and better able to use community resources and services.[6]

School programs

Schools have begun to take the lead with home visitation programs. Head Start, in the past few years, has added home visitation to its services.

In Fresno, Calif., a project called MIRROR (Managing Integrated Resources Reaching Out Remediation) uses community role models to help families and students at risk for school failure. Individuals from the community share their stories and experiences with others from their culture who face similar disadvantages. The project's goal is to increase family participation in a child's education. Activities include teacher and family training, a family-school retreat, planning sessions that include families, and tutoring.

Parent Training and Information Centers

A national movement by parents of children with disabilities that began in the 1970s resulted in a federal law in 1984 that established Parent Training and Information Centers (PTIs) in all states. Many of the staff members at these centers are parents of children with disabilities or have disabilities themselves. The goal of the program is to teach parents about their rights under the public education laws. Through this type of effort, advocates reach out to other parents to improve and expand opportunities that enhance the quality of life for children with disabilities and their families.

PACER Center, for instance, is the Minnesota Parent Training and Information center. PACER's programs help parents become informed, effective representatives for their children in early education, school-age and vocational settings. Through knowledge about the laws and parental rights and responsibilities, families are better equipped to work with agencies to obtain appropriate services for their children.

Models of parent-to-parent outreach and family-support programs are becoming more numerous each day. Some agencies and services already strengthen their programs with parent support groups. Perhaps more agencies, both public and private, soon will recognize the impact these programs can have and will add them to their services.

Chapter citations

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2. Michaud, I.L. *The Prevention Report.* Iowa City, IA: The National Resource Center on Family Based Services, 1992.
3. Allen, M.; Brown, P.; and Finlay, B. *Helping Children by Strengthening Families: A Look at Family Support Programs.* Washington, DC: Children's Defense Fund, 1992.
4. National Committee to Prevent Child Abuse. Reprinted with permission from NCPCA Memorandum, June 1992.
5. Ibid.
6. Stein, A. *Hennepin County Foster Care Policy Design Commission Report,* 1993.

Closing Statement

Professionals from both the public and private sectors have recognized that changes need to be made in the current system in order to reach the goal of preventing and responding to the abuse and neglect of children with disabilities.

Systems change does not come quickly. Families will discontinue services or reject them from the start if we do not respond to them respectfully. This means society must provide culturally sensitive assessments that are based on families' strengths, not their deficits. This means we must create and expand methods to reach families in poverty who may live in unsafe neighborhoods. This means we must find the mechanisms to reach those who have fallen victim to chemical dependency, abuse, hunger, homelessness and other social ills.

The future looks very bleak for many families. All our well-intended efforts will not promote change if families' basic needs are not met expediently and sufficiently.

Violence in all forms must be recognized and dealt with. Lost opportunities need to be recreated to guide families toward successful outcomes. The broken spirits of parents and children must be healed so they can find hope again. Parents of all children, regardless of ability, need to find other parents in similar circumstances so they can share their joys and sorrows and by doing so, help each other. No family should have to journey through each day alone. Families need to be respected and allowed to identify what is important to them. They can then chart their own journeys in building strong, healthy family units.

Every child has a right to see the love in a caregiver's eye. Every child needs the warmth of an embrace and a shoulder to cry on in stressful times. Every child needs to experience the joys of childhood instead of being recruited into urban gangs armed with guns.

We, as a nation, have the power to make this dream a reality for more families. We have the technology. We have the insights. The challenge is do we have the commitment to meet families at their point of hope rather than at their time of despair?

Appendix

Model support programs

upport programs that have had successful experiences include:

Massachusetts Parenting Partners

Department of Social Services
24 Farnsworth Street
Boston, MA 02210

Family Resource Centers

Some centers serve specific portions of the population, i.e. a specific ethnic group. Examples of Family Resource Centers are:

► The Family Place — Serves families who are new immigrants from Central America.

The Family Place
3309 16th Street, N.W.
Washington, D.C. 20010

► Family Focus — Operates in low-income, largely African-American neighborhoods in Chicago and serves many teenage parents.

Family Focus, Inc.
310 S. Peoria Street, Suite 401
Chicago, IL 60607

► The Parenting Center — Serves primarily middle-class families in which many mothers do not work outside of the home.

Parenting Center
Children's Hospital
200 Henry Clay Avenue
New Orleans, LA 70118

► Survival Skills Institute — Designed to affirm the unique strengths of black families while meeting their differing needs.

Survival Skills Institute
1501 Xerxes Avenue North
Minneapolis, MN 55411

► Avancé Family Support and Education Program — A "Fatherhood Project" is aimed at expanding the male's role in raising his child while experiencing personal growth.

Avancé Family Support and Educational Program
435 South San Dario
San Antonio, TX 78237

► MIHOW (Maternal Infant Health Outreach Worker) — A rural family outreach model using natural helpers and outreach workers.

MIHOW
Center For Health Services
Station 17, PO Box 567-VUH
Nashville, TN 37232-81803

Friends of the Family, Inc.

1001 Eastern Avenue, 2nd Floor
Baltimore, MD 21202-43644

Resource Mothers Consultant

Department of Nursing
Children's Hospital
700 Children's Drive
Columbus, OH 43205

STEEP

University Community Consortium
On Children, Youth and Families,
University of Minnesota
N645 Elliot Hall
75 East River Road
Minneapolis, MN 55455

Regional PTI Centers

Regional Parent Training and Information Centers, and the states they serve, are:

► Central Office — Federation for Children with Special Needs
95 Berkeley Street, Suite 104 • Boston, MA 02116
(617) 482-2915 (Voice & TDD) • FAX: (617)695-2939

► Midwest Regional Center — PACER Center
4826 Chicago Avenue South • Minneapolis, MN 55417-1098
(612) 827-2966 (Voice & TDD) • FAX: (612) 827-3065
Serving Colorado, Illinois, Iowa, Indiana, Kansas, Kentucky, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, and Wisconsin.

► Northeast Regional Center — Parent Information Center
151A Manchester Street, P.O. Box 1422 • Concord, NH 03302-1422
(603) 224-7005 (Voice & TDD) • FAX: (603) 224-4365
Serving Connecticut, Delaware, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Puerto Rico, Rhode Island, Vermont, and District of Columbia.

► South Regional Center
1851 Ram Runway • College Park, GA 30337
(404) 761-3150 (Voice & TDD) • FAX: (404) 767-2258
Serving Alabama, Arkansas, Florida, Georgia, Louisiana, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Virginia, and West Virginia.

► West Regional Center — Washington PAVE
6316 South 12th Street • Tacoma, WA 98645
(206) 565-2266 (Voice & TDD) • FAX: (206) 566-8052
Serving Alaska, Arizona, California, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Texas, Utah, Washington, Wyoming, American Territories, and the Department of Defense Dependent Schools.

National Parent Network on Disabilities
1600 Prince Street, No. 115 • Alexandria, VA 22314
(703) 684-6763 (Voice & TDD) • FAX: (703) 836-1232

Appendix

Family Preservation Act

President Clinton, in August 1993, signed into law the Family Preservation and Family Support Act (Public Law. 103-66).

With this legislation comes approximately $1 billion of new federal funding that will be distributed over a five-year period. The law mandates each state's public child welfare service agencies to assess and implement a plan that will focus on family preservation (services to families at risk or in crisis) and family support services (preventative services).

The new program also offers states an extraordinary opportunity to assess and make changes in state and local child welfare programs. The purpose of the changes is to achieve improved well-being for vulnerable children and their families, particularly those experiencing abuse and neglect or who are at risk. States are being encouraged to use the new program as a catalyst for establishing a continuum of coordinated and integrated, culturally relevant, family-focused services for children and families.

Among the elements that would ideally be part of the continuum, depending on family needs, are: child welfare services, including child abuse and neglect preventative and treatment services and foster care; services to support reunification, adoption, kinship care, independent living, or other permanent living arrangements; and linkages to services that meet other needs, such as housing, employment, and health.

In passing this legislation, Congress recognized that new funding alone would not be sufficient to meet the goals of the legislation and Public Law 96-272. Because new or expanded services are just one

element needed to improve the child welfare system, many states and communities may choose to carry out major changes in the ways services are delivered and in the systems that deliver them, in order to ensure that services are part of a comprehensive, coordinated service delivery system that draws heavily on community-based programs in its design and implementation.

Therefore, the federal government expects that a major goal of the planning process will be to examine the changes that are needed in each state to make delivery of services more responsive to the needs of individuals and communities and more sensitive to the context in which they are to be delivered.

How can service providers or parents have an voice in this process? They may contact the State Department of Child Welfare Services; ask to be on the planning team for the new Family Preservation and Family Support Act; ask to serve on a committee that will have an impact on how this legislation will be implemented; offer to set up a focus group to ensure the needs of the community are heard; ask to distribute survey or other information that is supposed to extract the needs for the state in regard to the delivery system; help to find parents and professionals who want to testify or address how change could create system's more responsive to family needs; or ask to be a contact person for any public service announcements or newspaper articles that may be distributed to communities.

This new federal law creates an opportunity for the average citizen to provide the larger system with the information of what families need in services and resources to maintain their strength and health.

Appendix

Related PACER materials

Preschool Family Strengths Program

Celebrating Family Strengths: Preschool Curriculum Guide

Lessons assist early childhood educators and providers of early intervention services in encouraging children to develop a strong positive view of themselves and their families. 25 pages. 1994.

$10 — 10 or more, $8 each

Celebrating Family Strengths Parent Newsletter

Offers ways for families to follow up the message of the puppet shows for their children. Features a month-long calendar of fun activities for parent and preschooler. 1994.

$1 — 10 or more, 50 cents each

"I Am Special" Activity Books

In coloring these pictures, children learn how each person and each family is unique and important. 13 illustrations plus an award for the child who colors them. 1994.

$1.75 — 10 or more copies, $1.50

"Families Are Special" Audio tape

The "Families Are Special" theme song, along with songs like "Growing Up," the "Rainbow Song," and "Mop the Floor" are excellent entertainment. They reinforce the messages children learn from "Family Strengths" puppet shows. 11 minutes per side. 1994.

$5 — 10 or more, $4 each

Family Strengths Early Childhood Package

1 preschool curriculum, 1 audio tape, 10 activity/coloring books and 10 newsletters.

$25

Elementary Age Family Strengths Program

Celebrating Family Strengths: K-3 Curriculum for Educators

Includes exercises for students in grades K-3 to enhance the ideas from the Family Strengths puppet show and Handbook for Families. 42 pages. 1993.

$10 — 10 or more copies, $8 each

Celebrating Family Strengths: A Handbook for Families

Suggests ways for families (including single parent homes, step families, etc.) to recognize and appreciate their own strengths, stories and traditions. Reinforcing concepts taught in the Family Strengths puppet show, it expresses the need for good communication, positive messages, times to ask for help and recognizing responsibilities. 24 pages. 1993.

$2.50 — 10 or more copies, $2 each

Let's Prevent Abuse Training Materials

Information Guide for Educators and Other Professionals

This ready-reference series of file folders will help you pull out facts quickly on child maltreatment in general and as it pertains to children with disabilities, families at risk, the types of abuse and neglect, reporting policies, and discussing abuse with a child. 36 pages. 1989.

$6 — 10 or more copies, $4.50 each

Prevention Handbook for Early Childhood Professionals and Families with Young Children

Deals with the maltreatment of young children by looking at causes, statistics, signs of abuse, laws, means of prevention, and local resources to contact. It is recommended for people who work with families who have children with disabilities five years old or younger. 114 pages. 1991.

$10 — 10 or more copies, $8 each

Resource Manual on Child Abuse

Information on abuse prevention for use by parents, teachers, and professionals who work with children. Covers the incidence of abuse of children with disabilities, types of abuse, laws, legal and social systems, interviews with victims, a bibliography, and resource lists. 116 pages. 1988.

$10 — 10 or more copies, $7.50 each

Training of trainers' on abuse prevention

PACER's Let's Prevent Abuse Project will conduct national Training Institutes focusing on families of children birth through age 5 with disabilities who are at risk for potential abuse and neglect.

Funded by the Office of Special Education, Division of Personnel Preparation, the four-day training institutes spring from the need by families for more support and resources to achieve optimal family relationships, and by many professionals to know how to help more families.

For ordering information on materials, call PACER at (612) 827-2966, Voice and TTY